The
# Public Health Nurse

Volume XVII April, 1925 Number 4

## Should Nurses Do Intelligence Testing?

*By Frankwood E. Williams, M. D.*

# *The* PUBLIC HEALTH NURSE

*Official Organ of The National Organization for Public Health Nursing*

Volume XVII APRIL, 1925 Number 4


## EDITORIAL

The general interest in the tremendous progression of the Negro race from "90 per cent illiteracy" sixty years ago to "90 per cent literacy" to-day has been greatly stimulated by the large sum recently appropriated by the Government to Howard University in Washington, and the recent gift of Mr. John D. Rockefeller and the conditional gift of Mr. George Eastman to the fund being raised for the extension of the work of those two remarkable educational institutions—Hampton and Tuskegee. There are few spectacles in this kaleidoscopic country of ours more extraordinary than the transformation within these sixty years of a people starting in enforced ignorance and poverty to the race consciousness of to-day. This is admittedly largely due to the influence of Hampton and Tuskegee.

At the same time that our attention was called to these gifts to Negro education, we received a copy of a study of educational opportunities in nursing for colored women. An abstract of this study is published elsewhere in this number of the magazine. This study brings very definitely to our attention the fact that facilities for the education of colored nurses are proportionately meager. Very little money or thought has yet been put into this important vocation for colored women.

In public health nursing the same educational facilities are available in the North to colored nurses as to white nurses. In the South, however, no postgraduate courses in public health nursing of standard quality for colored nurses have yet been developed. We have every reason to believe and hope that such courses will be made possible in the near future.

The study of which we have spoken represents an immense amount of work and was made by the Hospital Library and Service Bureau of the American Conference on Hospital Service. It is a most valuable contribution to our somewhat scanty knowledge of this subject, and will serve as a basis for future studies and information.

The Statistical Department of the N.O.P.H.N. is now collecting data on the number and distribution of Negro nurses in public health services which we hope will soon be available.

# CONFERENCE ON THE GRADING OF NURSING SCHOOLS *

On March 4, 1925, two committees of three each, from the National League of Nursing Education and from the American Medical Association, called together in New York City a group representing nursing associations and agencies, national medical associations, representatives from the field of education and from the public interested in nursing education to discuss a grading for nursing schools in the United States. Dr. Darrach, Chairman of the A.M.A. Committee, acted as chairman.

The conference was the culmination of years of effort on the part of the National League for Nursing Education and in lesser degree of all the groups represented.

At the last meeting of the joint boards of the three national nursing organizations, Mrs. Chester C. Bolton of Cleveland pledged to underwrite this project for the first year (and said she would not desert it the following two years) to the amount of $15,000. The joint boards then voted to undertake to raise the remainder of the necessary funds, approximately $10,000 to $15,000, for the first year's work.

On the basis of this assured support, the conference of March 4 agreed that the project of rating or grading nursing schools should be immediately undertaken. It was decided that a committee for this project be formed of delegates from the following groups:

The American Nurses Association—two delegates.

The National League for Nursing Education—two delegates.

The National Organization for Public Health Nursing—two delegates.

American Medical Association—one delegate, one alternate.

American College of Surgery—one delegate, one alternate.

American Hospital Association—one delegate, one alternate.

American Public Health Association—one delegate, one alternate.

This group will add to itself representatives from the field of general education and from the interested public. After the general policies and plans have been drawn up and approved the committee will proceed with the actual rating.

As we nurses in the public health field attempt to meet the increasing demands and opportunities of our special field, we become more and more conscious of the need for a sound and broader fundamental education in nursing. At the same time we realize that the opportunities and demands upon nurses in the public health work are fundamentally the same as in other fields of nursing, broadly interpreted. Only as nurses receive an education which makes it possible for them to function in the preventive and educational aspects as well as in the remedial aspects of nursing work, will they be able to meet adequately their opportunities and responsibilities.

That a definite improvement in nursing schools will result from such a grading scheme—whose primary purpose is the education of all groups concerned in this question—is inevitable. That this will react directly upon the quality of nurses in public health work is also inevitable.

There have been many difficulties in developing this project to the present point and equally great problems will be involved in carrying out this plan. Since we believe that such a step is necessary to the development of nursing, let us as individuals feel a real responsibility for forwarding this project. This is possible in two ways—first, through subscribing to funds for this purpose and, second, through alumnæ loyalty, not in justifying poor practices of the past, but in helping to improve the schools from which we have graduated.

* See preliminary announcement in February, 1925, number, page 60. Also *American Journal of Nursing*, current numbers.

# THE AIMS AND PROGRAM OF SOCIAL HYGIENE

By M. J. Exner, M.D.
American Social Hygiene Association

IN THE United States social hygiene embraces study of the attempted solutions of the sex-social problems, including both their constructive and their destructive phases. Outstanding among these are the problems of sex education, sex-social relations, use of leisure, eugenics, marriage and divorce, prostitution and other forms of sex delinquency, defective offspring, and other problems arising out of sex maladjustments and out of the effort to secure a more constructive use of the sex factor in human life.

The instincts of sex and reproduction belong to the basic natural endowments which are the raw materials of life and out of which personality and character are developed. Like most basic endowments, the sex instinct has no inherent moral quality. It is neither good nor bad in itself. However, it eventually pervades the whole of life from the physical to the highest emotional, social, and spiritual activities, and has tremendous capacity for good or for ill—capacity, on the one hand, for developing, enlarging, and enriching life, and equal capacity, on the other, for destroying and degrading life and spreading anti-social results. What its contributions to life and society shall be, depends mainly on the way it is directed by the individual as a result of his education and training.

Sex problems result from the misdirection and mismanagement of this native endowment. It is the purpose of social hygiene to promote such understanding and guidance of sex as will assure its most upbuilding contributions to life and foster increasingly sound adjustment of the individual to his sex environment. Toward this end, it seeks to utilize more and more extensively the two essential means available for securing this adjustment, namely, the influence of wisely directed education and the influence of wholesome environment.

### *Education*

Social hygiene education seeks, through a better understanding of sex in its physical, emotional, and social aspects, to establish a rational basis for sex guidance and control, to teach the constructive use of sex for normal self-development and social good, and to foster a wise selection of mates, happy marital relations, and successful parenthood—all with this objective: to make increasingly possible for the individual a more complete realization of his sex life as well as his harmonious adjustment to society.

The educational program of social hygiene presents two aspects:

*First,* informing the general public in order to secure an understanding and appreciation of sex-social problems, with a view to fostering intelligent and united community effort directed toward their solution. To this end, based on scientific research—sound experience is given publicity, by such means as lectures, conferences, institutes, printed matter, exhibits, motion pictures, and radio talks. This effort to enlighten public opinion may well be the work of a Department of Public Information.

*Second,* the education of the oncoming generations in understanding and attitude with respect to sex and reproduction as a means toward a happy personal and social adjustment and eugenic mating. Such education has come to be called " sex education " or " sex-social education," or, because of its close connection with character development,

" sex-character training." It seeks to bring to the aid of the individual at every step of his sex development the best knowledge, the soundest interpretation of racial experience, the most powerful incentives, and the most wholesome example, to enable him to direct his sex endowment to his fullest self-development, to the enrichment of his life, and to the good of society.

In the light of experience, it seems hardly wise to foster sex-social education as a separate, isolated feature, but rather to promote its normal integration at the appropriate points in the whole scheme of training for life. Sex is a normal factor and one of the most powerful influences in life as a whole. It must take its appropriate place in education as a whole. The primary responsibility for correct sex information and sound sex attitudes in the formative years of childhood rests upon the home. However, the elementary schools must supplement the education of parents with more orderly, scientific teaching concerning the universal processes of sex and reproduction, in order to reinforce a normal, scientific, unemotional attitude toward these processes. Where homes are unable to meet their responsibility, the brunt of the task must fall on the schools. The secondary schools in turn must furnish a correct knowledge of the new and powerful physical and emotional sex factors which complicate the problem in adolescent years, and an adequate interpretation for intelligent guidance and control. The universities and colleges must enlarge upon this fund of information and interpretation both as a basis for immediate adjustment and in preparation for successful marriage, parenthood, and citizenship. The church and all religious agencies, which peculiarly assume the functions of character training and of social adjustment, must study this basic factor of sex in life and guide it constructively for sound development of character and for socially serviceable ends. The same responsibility rests upon all other educational and social agencies which have to do with the education and guidance of young people. Upon the community as a whole rests the responsibility, among others, for sustaining a clean, wholesome public sentiment concerning sex, such as will tend to reinforce the best ideals of its young people.

*Environment*

In the environmental aspect of the social hygiene program the following measures have so far become standard:

*Legal Measures.* These are chiefly to repress prostitution, to frame appropriate uniform laws in the interest of social health, to promote their adoption and enforcement, and to remove unjust inequalities in existing laws. The sex appeal lends itself to commercial exploitation more readily and extensively than any other human interest. Unscrupulous exploiters are ever ready to take advantage of this fact. Hence, the total volume of prostitution in any given community where no restriction is exercised is always likely to be far in excess of what might be regarded as a spontaneous demand in our ill-adjusted society, and it is certain to be in forms which are most dangerously alluring to the naturally curious adolescent young people. Experience has proved that by consistent application of appropriate legal measures it is possible to eliminate to a large extent that great proportion of the total volume of prostitution which represents an artificially (commercially) stimulated demand, and, if not to eliminate, at least to reduce the remainder to less conspicuous forms far less tempting to young people.

*Protective Measures.* These are designed to safeguard the moral integrity of the young people of a community, especially those who by reason of environmental influences or inherent lack of moral resistance are peculiarly exposed to moral dangers. The policewoman, the school-home visitor, the Travelers' Aid, the juvenile and domestic relations court, the detention home and the farm for rehabilitation of sex delinquents are some of the

agencies used, while the supervision of dance halls and places of amusement, the provision of adequate lighting for streets and parks, and the betterment of court procedure are some of the objectives for these protective measures.

One of the most important factors in the social hygiene problems of the community is the character of its play and amusement and the facilities provided for them. No other consideration is more important than the wholesome direction of the leisure of young people. Hence protective measures aim particularly to encourage the provision of adequate facilities for wholesome play and recreation and to assure the decent character of the community's amusements.

*Medical Measures.* Promiscuous sex relations cause the spread of two of the most serious diseases known to man; namely, gonorrhea and syphilis. From the beginning, social hygiene has addressed itself to combating this social menace. It has promoted a continuous campaign of publicity concerning the character and dangers of these diseases, and of educating physicians to more serious and systematic attention to their prevention and cure. Increasingly it is securing the provision of more adequate hospital and clinical facilities for early diagnosis and treatment, and fostering the development of the same control of and attitude toward these diseases on the part of the official health authorities and physicians as is being exercised in relation to other communicable diseases. Great strides have been made toward the ultimate control of this social menace by securing the coöperation of an informed public, of the health and medical agencies, and of other interested organizations.

It is important to recognize the intimate relation between educational and environmental social hygiene measures. By themselves, environmental measures are only palliative. They secure in the main only external safeguards for the individual. By themselves, educational measures, which secure internal safeguards provided by effective personality and sound character, are more important. These character controls imply high ideals, sound attitudes, fine tastes, and wholesome standards and habits with respect to sex. Such character traits and integrity must be fostered by progressive, consciously directed education and guidance. However, human nature being what it is, with primitive instincts close to the surface, even the most ideal education cannot accomplish the desired results in a vicious environment. The task of the community is to make its environment clean and wholesome in order that it may support a sound educational program. Educational and environmental social hygiene measures must go hand in hand, mutually supplementing and supporting one another.

Social hygiene seeks to promote such a balanced and inclusive program toward the end of solving sex-social problems and of realizing for the individual and society the fullest constructive contributions of his sex endowment.

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II. Pamphlets*
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263—What to read on social hygiene
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* Publications of The American Social Hygiene Association, 370 Seventh Avenue, New York, N. Y.

# POSSIBLE SCHOOL PROJECTS FOR PARENT TEACHER ASSOCIATIONS TO SPONSOR

School nurses are often asked for definite suggestions for projects in connection with Parent-Teacher Activities. These suggestions by Dr. Sherman will, we think, be welcomed.

Clean, sanitary and attractive school buildings.

Follow-up supervision of the same.

Suitable playgrounds with equipment.

Preschool age health clinic.

A full-time school nurse for every 2,000 children.

A part-time school doctor, nurse and dentist for every community. (Possibly District Plan.)

A dental hygienist for every 2,000 children.

Milk for undernourished children.

Hot luncheons for teachers and children remaining at school, with equipment for same.

Scales, with measuring rods.

Adjustable and healthfully built seats and desks.

Supply health charts.

Open air schools and equipment.

Classes for exceptional children.

Classes for crippled children.

Classes for speech defects.

Classes for sight conservation.

Schick test and toxin-antitoxin immunizing for all children.

Loaning automobiles for children needing clinic and hospital service.

Assisting teacher and nurses or older girls in organizing and conducting school lunches.

Visiting homes, physician and dentists for the purpose of securing corrective need for financially handicapped children.

Finding comfortable and pleasant places for teachers to live.

Providing suitable rest rooms with equipment for teachers.

Knowing the individual teachers (especially the one who is teaching your child).

Extending hospitality to the teacher group.

Supplying educational journals for teachers use.

Supplying phonograph and records.

Supplying thermometers.

Supplying window boards.

Sponsor the school housekeeping of the school in your community.

Providing a committee for this purpose which shall function throughout the year.

Making the school a vital civic project.

## *Points to Note When Parent-Teacher Association Members Visit Schools*

Is the teacher an example of health, alert and keen?

Is the building clean, bright and attractive?

Is there a thermometer correctly placed?

Is the temperature between 65° and 70°F.?

Is the ventilation good and how secured?

Is the stove jacketed (if one used)?

Is the room overcrowded?

Are the desks and chairs adjustable?

Does the light come from the left side or left and rear?

Are there window shades?

Are the blackboards properly placed?

Are dustless crayons used?

Is there moist dusting and sweeping?

Are the books clean and fresh?

Are there postural and breathing drills, and how often?

Are they given with open windows?

Is the water supply healthful?

Are there drinking fountains or individual cups or covered porcelain water containers?

Does the drinking fountain make mouth contact impossible?

Are the toilets clean, free from odor, well ventilated?

Is there toilet paper?

Are there facilities for washing the hands? (Liquid soap and paper towels?)

Is there adequate fire protection?

Is there adequate and suitable playground?

Is the playground supervised?

FLORENCE A. SHERMAN, M.D.,
*Assistant State Medical Inspector of Schools,*
*Albany, N. Y.*

# OREGON THE MAGNIFICENT

By Florence Grandy
County Nurse, Roseburg, Oregon

*Third in the Series of "Our Adventurers"*

A COUNTY health unit came to Douglas County, Oregon, last February, two nurses and a clerk. Both nurses were from the east and were thrilled at the idea of working in this vast county which is larger than the state of Connecticut. Connecticut has 1,300,000 population and Douglas County has only 21,000.

We are situated in an immense mountain basin, completely sheltered on all sides, with the great Umpqua River extending from Diamond Lake near the Crater Lake National Park more than 200 miles to the Pacific Ocean, it and all its tributaries being contained in Douglas County. This river flows through forests of pine, fir, and cedar, one-fortieth of the standing timber of the United States. In the valleys are thousands of fruit trees—prunes, apples, peaches, apricots—and on the rich lowlands grow fields of broccoli, or winter cauliflower, which is harvested in February.

I will never forget our first few weeks here. Everything was new and strange to us, even the accent and the idioms. It was delightful to hear nothing but good old "United States" spoken, 92 per cent of the people being American.

The way had been paved for us, especially in the country districts, for the county school superintendent and county school supervisor had built up a very efficient administration. They had encouraged the teaching of hygiene and were enthusiastic supporters of the county health unit. We were deluged with calls. If one visit were 40 miles to the north, the next would probably be 50 miles to the south, and these outlying districts were so eager for the visits of the nurse.

We had some trouble with contagion at first. In days gone by smallpox and scarlet fever cases roamed the streets at will. Several bad epidemics of diphtheria had made the people more afraid of that than anything else, but they couldn't understand why they should stay at home and have a pretty sign on the house. That wasn't any way to treat an old timer!

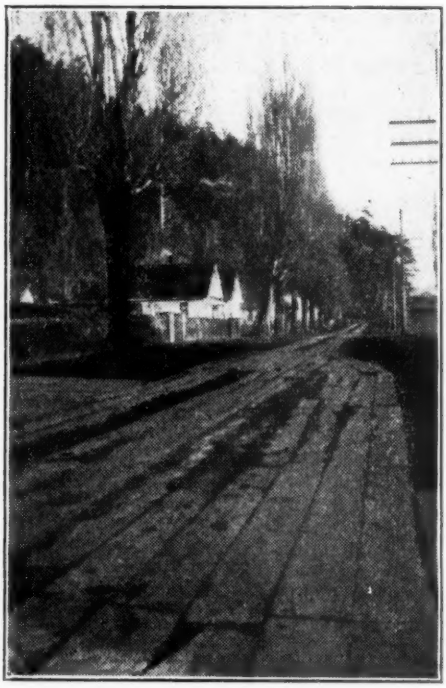
We placarded for measles in one community up in the mountains and

*The Nurse's Own Cabin in the Hills*

tried our best to stamp out the contagion and if we missed some of those people they were quite insulted. They wanted the same attention and instruction that the others had had, even though they were living up some trail a long way from their neighbors.

One young fellow, a strapping six-footer, twenty years old, had been out of school several years when, deciding he wanted more education, he had come back to the ninth grade in the high school. He lived on a home-

stead on the mountain side way back in the woods, and we found him beautifully mottled with the measles. His sister came to care for him as he became very ill. We placarded his cabin and when we went back to remove the sign, he asked if he might keep it as a souvenir and in return gave us a very fine dinner. The log cabin was spotless and he had his favorite movie actresses' pictures tacked on the wall and framed in Oregon grape.



*Just Across the Umpqua is Gardiner, a Picturesque Little Fishing Town*

In our coast communities there seems to be little contagion. It is the exception rather than the rule to find a case of scarlet fever or diphtheria. The inhabitants are isolated to a great extent from the rest of the county by a great mountain range, although a beautiful highway will be open next year by the side of the Umpqua River which flows through this range. Heretofore our only way to reach this community was by stage over an awful road to Scottsburg and thence down the Umpqua River to the sea. The scenery on this trip is indescribable. There are no roads, or at least very few, in this section of Douglas county.

### *A Town on Stilts*

The town of Reedsport is built on stilts. When the tide comes in it runs up all the little creeks and under the streets. All travel in this section is done by gasoline boats which travel at the rate of about four miles an hour. We usually hire a fish boat when we make calls on Smith River and the smaller sloughs. The fishermen are only allowed to fish at night and are at liberty to carry passengers during the day. Everything from a grand piano to a load of hay is transported on scows. These scows are attached to gasoline boats and they go puffing merrily up and down the river.

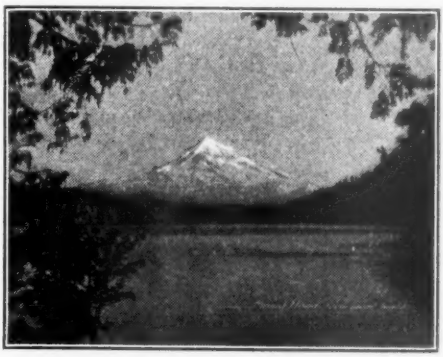
These sections around the sloughs and rivers are very productive. I have never seen richer milk or finer fruits and vegetables, and the children are sturdy and strong and happy looking. The people are very progressive. In a great many instances the mothers are ex-school teachers. (We have only found one ex-nurse so far.) They are very hospitable and welcome the nurses' visits. In fact these visits in a great many of these communities are social occasions, the mothers gathering at one home anxious to bring their problems to us.

We have wonderful roads, considering the mountainous community we live in, although many of them are impassable in the winter time. As yet, we have not had to go horseback, but the doctor has done so a number of times. He takes his car as far as possible and they meet him with a saddle horse. We had a 15-mile walk last spring over impassable roads, but it was a delightful trip. We visited two schools at logging camps. The loggers were coming down in trucks every day, but how they ever did it is a mystery.

We were given a lift the last long mile to Panther Butte in a dilapidated Ford, vintage of 1920 or thereabouts. There was a steep gulch on one side

of the road, planks upended in the middle, chuck holes, mud, etc. The driver became quite interested when he found we came from the same home town and turned around in order to talk with me more freely, still driving at the rate of about 25 miles an hour. About that time we took a long look at that yawning gulch and expostulated vehemently, "You're not in Michigan now! Keep your eye on the road!" However, I think the driver could have gone over that corduroy trail with his eyes shut, and we arrived in safety.

No matter how far into the interior of this county we may go, no matter how wild and rough the country is, we find tucked away in these tiny hamlets college bred, refined people, some of them of world wide fame. It is a beautiful country and a wonderful climate at all seasons of the year and they are content to live here away from the world. We feel that we are very fortunate, not only in having such wonderful people to work with, but that we also live in such beautiful surroundings.



*Mt. Hood, another wonderful view in Oregon*

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## THE DECLARATION OF GENEVA

*Done into English Verse by Ethel Sidgwick*

I. The Child a birthright shall inherit
For natural growth in flesh and spirit.

II. The Child a-hungered shall be fed,
The sick child nursed and comforted,
The backward child with patience led;
The erring shall be claimed from sin,
The lonely child, bereft of kin,
Unloved, shall be taken in.

III. In dire catastrophe and grief,
He shall be first to have relief.

IV. Betimes the way he shall be shown
To earn his bread and stand alone.
None shall exploit him, yet ungrown.

V. And this, his trust, shall be defined;
The best of him, of heart and mind.
Is at the service of his kind.

Copies may be had from the offices of Save the Children Fund, 26, Gordon Street, London, England. Price, 6 cents each.

# SUMMER SCHOOLS AND INSTITUTES OPEN TO PUBLIC HEALTH NURSES, SUMMER OF 1925*

The following departments which offer a year's course and certificate in general public health nursing have written to headquarters announcing summer sessions:

*California*

University of California, Berkeley, June 22 to August 1
University of California, Southern Branch, Los Angeles, June 22 to August 8
Miss Edith S. Bryan, Director

*Iowa*

University of Iowa, Iowa City, School of Public Health Nursing, six weeks
Miss Helen F. Boyd, Director

*Michigan*

University of Michigan, Ann Arbor, Department of Nursing, eight weeks, June 23 to August 14
Mrs. Barbara Bartlett, Director

*Minnesota*

University of Minnesota, Minneapolis, Department of Preventive Medicine and Public Health, six weeks Theory, June 19 to August 1; three months Field, June 19 to September 26
Miss Eula Butzerin, Director
Special Institute in Tuberculosis, June 15–19, at time of meeting of National Tuberculosis Association

*New York*

Columbia, Department of Nursing Education, Teachers College, six weeks, July 6 to August 15
Miss Lillian Hudson, Director

*Ohio*

Western Reserve University, School of Applied Science, four months field work with correlated instruction in special fields in public health nursing beginning May 4
Miss Marian Howell, Director

*Pennsylvania*

Pennsylvania School of Social and Health Work (Department of Public Health Nursing), Philadelphia, six weeks, July 6 to August 15
Miss Harriet Frost, Director

*Tennessee*

Peabody College (Department of Nursing Education), Nashville, six weeks, June 8 to July 16
Miss Abbie Roberts, Director

*Washington*

University of Washington, Seattle, six weeks summer session, including one week Institute beginning July 13, in coöperation with the State Nursing Association. This institute will have Miss May C. Wheeler and Miss Cecelia Evans as special lecturers
Mrs. Elizabeth Soule, Director

For information concerning tuition and other expenses, living conditions, special courses, field expenses, scholarships available, special railroad rates, etc., write directly to the department offering the course.

*Special Courses for School Nurses*

Hyannis Normal School in conjunction with the Department of Education of the State of Massachusetts, Hyannis, Mass. Address Dr. Frederika Moore, Massachusetts Department of Public Health, State House, Boston, Mass.

State Normal and Training School, Oswego, N. Y., July 6 to August 14. Director, Miss Sarah E. Olmsted.

Pennsylvania State College, State College, Pennsylvania, eight weeks. Director, Miss Anna L. Stanley.

* A supplementary list will be published in the May issue.

## OTHER COURSES OPEN TO PUBLIC HEALTH NURSES OF WHICH WE HAVE ANNOUNCEMENTS ARE:

Stanford University, Palo Alto, California, July 23 to August 29. Director, Miss N. F. Cummings, Assistant Professor of Nursing. For further information address Registrar, Stanford University.

Six weeks courses for Red Cross Home Hygiene Instructors and other nurses interested to become instructors will be held at the Pennsylvania State College, State College, Pennsylvania; Colorado Agricultural College, Fort Collins, Colorado; Simmons College, Boston, Massachusetts, and probably in two other places (in the south and on the Pacific coast) to be announced next month.

Intensive Course in Public Health Record Keeping, Massachusetts Institute of Technology, Boston, Mass., three weeks, July 6–24. Director, Professor Turner. Thirty-hour course in record keeping, organization and presentation of health statistics in the work of school and health departments and private health agencies.

Institute for Nurses under the Illinois State League of Nursing Education, ten days in August. For information address Miss Mary Kennedy, 6400 Irving Park Boulevard, Chicago, Illinois.

Smith College—School for Social Work, Northampton, Mass., July 3 to August 29, 1925. Courses in Social Work especially related to Mental Hygiene. Everett Kimball, Ph.D., Director. Scholarships—Five $1,200 fellowships for psychiatric social work are available at this school for students entering July, 1925, for the full course (of approximately fourteen months) who are college graduates experienced in social work.

*Physiotherapy*

Harvard Medical School, Children's Hospital and Allied Institutions, June 16 to August 18, 1925. Secretary, Courses for Graduates, Harvard Medical School, 240 Longwood Avenue, Boston, Mass.

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## WHERE THE OLD ORDER DOES NOT CHANGE

It is the way of the world to bemoan the good old days of our forefathers and to cite them as models in any subject from old-fashioned winter to old-fashioned morality. But a few of their customs we must admit have been improved upon even if in the improvement they have lost the picturesqueness of former ways.

Miss Amy Tapping has sent us this account from the fascinating "Journal of a Lady of Quality," written in 1775 by a Scotch woman who visited the Carolinas just before the Revolution:

> They are the worst washers of linen I ever saw, and though it be the country of indigo they never use blue, nor allow the sun to look at them. All the clothes, coarse and fine, bed and table linen, lawns, cambricks and muslins, chints, checks, all are promiscuously thrown into a copper with a quantity of water and a large piece of soap. This is set aboiling, wnile a Negro wench turns them over with a piece of stick. This operation over, they are taken out, squeezed and thrown on the Pales to dry. They use no calender; they are however much better smoothed than washed.

Yet in 1924 the same process was in vogue in a small Georgia town. And here is a photograph to prove it, showing all the clothing boiling away merrily in a great "copper" while the laundress "turns them over with a piece of stick."

# A PIONEER SELF-SUPPORT HEALTH SERVICE*

By Olive B. Husk
Late Director of the Manhattan Health Society

**Note: The Records and Reports of the Manhattan Health Society have been placed in the National Health Library to be used for reference purposes by any one interested in a similar project.**

THE recently concluded Manhattan Health Society Demonstration in New York City has brought to light the many difficulties to be confronted in establishing a "self-supporting health service in a Metropolitan District." The lack of community spirit; ignorance of the value of health education; the accessibility of free service for this class whose pride does not prevent their accepting it; the pride of another class who do not wish to accept anything which in their minds has a tinge of charity or free service; the constantly shifting population—all are contributing causes working against this new idea.

The Manhattan Health Society Demonstration covered practically a four year period—one year of which was devoted almost entirely to research and study of nursing organization, mutual benefit association, and to local propaganda, publicity and organization. The actual service period approximated two and one-half years. During this time 730 memberships were issued, 95 per cent to individual members and 5 per cent to family groups—making a total of 867 individuals entitled to this service of the Society. Forty-nine and six-tenths per cent of the memberships issued were for babies under one year of age—which is significant not only as indicating the most popular service but a difficulty in a self-governed organization.

Eleven and three-tenths per cent of enrolled membership had prenatal care —50 per cent of the prenatal cases were delivered in homes, 24 per cent in hospitals and 16 per cent were dropped from membership before delivery because of removal from the district.

A total of 138 nursing care cases were carried. Periodic medical examinations for adults were given by appointment. Twenty-six different nationalities were represented in the membership group—54 per cent were American born of the second generation or more.

Forty-one per cent of enrolled membership were referred by members who had had service. Only 4.1 per cent paid up memberships were renewed for this second year—one of the most discouraging points, indicating the "value placed on sickness care rather than that of health protection."

The highest point of self-support was reached during the second year, when the income from membership fees equaled 20 per cent of actual cost of service. The total cost of Demonstration, including study and research work, publicity and organization, professional services, etc., was $42,065.61. The total cost of service over a period of 28 months was $27,932.06, the average cost per individual member, $30.07. Yearly individual membership was $10 —yearly family membership, $20.

The Demonstration was officially concluded with the withdrawal of the subsidy, so generously provided by an "Anonymous Donor." An immediate reaction on the part of an appreciative group of members was to organize as the "Co-operative Health Center of Washington Heights" on a more limited budget and it was hoped the community spirit of Washington Heights would get solidly behind this group. Again, unfortunately, community spirit in New York has failed and it is left to some smaller city or town to demonstrate what a "Co-operative Community Spirit" can do.

* An article on the Demonstration appeared in the January, 1924, number.

# SIGHT SAVING CLASSES

By Winifred Hathaway
Secretary, National Committee for the Prevention of Blindness

IN the early settlements of America the education of the child was given most careful consideration and in time the public school became an integral part of every community. Early in the nineteenth century those interested in blind children realized that because they could not see with their eyes was no reason why they should not be given an education, hence schools for the blind with methods specialized to meet the needs of finger readers began to be established. At the present time provision is made by every state for the education of its blind children.

These educational advantages have long been given to both normally sighted children and blind children; it was not until the second decade of the twentieth century, however, that serious consideration was given to the education of children who suffered from such visual handicap that they could not see well enough to take their work with the normally sighted, yet had too much sight to be finger readers. They occupied a very unstable position between the two, often with most disastrous results.

To be sure there were certain avenues open to them:

1. To strive to keep up with normally sighted children.
2. To enter a school for the blind.
3. To be deprived of all educational advantages.

All these avenues, however, led not only to the disadvantage of the child concerned, but to the disadvantage of those with whom he came in contact. If he followed the first avenue he became a chronic repeater or put an almost unbearable strain upon his sight and his general health in an attempt to keep up with his classmates; since, in either case, he had to be given a disproportionate amount of the teacher's attention, the other children were likely to be hindered in their work. If he attended a school for the blind, since eyes were made for seeing, he would read with them the raised dots meant only for finger reading thus putting an added strain upon sight which could ill afford to bear it; he selected his companions among the blind rather than among the sighted; because of his advantage over his blind companions in having some sight he very often obtained an exaggerated idea of his importance not only to his own detriment but decidedly to the detriment of the blind children for which the school was established. If he followed the third avenue he became a drudge of society, entering blind alleys of employment and increasing the turnover of labor which results in inefficient service and an increased price to the consumer.

Like most superintendents of schools for the blind, Mr. Edward E. Allen of Perkins Institute for the Blind, accepted many of these children in his school because this appeared to be the best of the opportunities offered. He early recognized the problem of having sighted children in a school especially adapted to the needs of blind children. In 1909 he went to England to make a study of the classes for myopes that had been established in London by Dr. N. Bishop Harman. The method of instruction used in these schools seemed to him to make possible an education not only for myopic children, but for all children with seriously defective vision without detriment to themselves or their neighbors, and on his return he brought this message of hope to America.

It was not until April, 1913, that, chiefly through his influence, the first sight saving class in the United States was opened in Boston. Mr. Robert B. Irwin of the Cleveland, Ohio, Department of Education, had been working along similar lines and in September of the same year he estab-

lished in that city the second class in the United States.

From this small beginning sight saving classes have very slowly found their way into the educational system of 57 cities. At the beginning of the school term February, 1925, the number of classes was 207. There are many reasons for this slow development: The expense of establishment and maintenance; the small number of children who can be cared for by the teacher; the lack of suitable equipment and especially the dearth of trained teachers. It is felt, however, that the experimental stage has now passed and that sight saving classes will soon become a recognized part of every efficient school system.

So many people are directly or indirectly concerned with these classes that a very definite exposition of their right to exist and of the safeguards and methods of education used in them may help to clear away any misunderstanding.

The first question that arises is the *number of children* requiring the advantages of sight saving classes; this fluctuates with the efficiency of school medical inspection and follow-up work. In general it may be said about one child in every five hundred of the school population is a candidate.

The second question relates to the *types of children* eligible for admission; these fall into two fairly definite groups:

**Children having between 1/10 and 1/3 vision after correction and necessary treatment.**

**Children with progressive eye troubles even though they may have almost normal vision.**

In general children with 1/10 vision or less are considered blind for all practical purposes and should be educated as finger readers. Except in cases of children with progressive eye trouble, children with 1/3 vision or over can usually carry on their work successfully in the regular grade although children with less than 1/2 vision in the better eye are doubtless potential candidates for sight saving classes.

How are these children to be found? Naturally great difficulty would be avoided if all children could be examined by an ophthalmologist before entering school, once during their school life in elementary grades and at graduation. But since this does not seem likely to be put into practice in the near future, another method of finding these children must be pursued.

The first responsibility should rest with the parents. Parents, however, are seldom trained to understand what should be done for their children in case of physical handicaps. The first responsibility therefore often devolves upon the teacher who has almost unlimited opportunity to learn the assets and liabilities of her pupils at first hand. She may not know what the difficulty is, but she can readily learn to recognize such symptoms as red or watery eyes, headaches, holding the book too close to or too far from the face, difficulty in seeing the blackboard or printed page, distortion of the face when trying to see, nausea, undue fatigue, listlessness, holding the head on one side and, in general, inability to accomplish average work. All these symptoms may not mean eye trouble, but they should indicate to the teacher the necessity of reporting a child suffering from any of them to the school nurse.

The school nurse is not expected to diagnose; she should, however, be able to make accurate vision tests and to recognize all the common eye diseases and eye defects. It is her responsibility to pass on children needing special attention to the school physician who in turn should recommend to the parents skilled attention.

The nurse should then follow up the cases and see that proper attention is given. By this method children needing the advantages of sight saving classes should readily be discovered.

In addition nurses, physicians and social service workers in general clinics as well as in eye clinics should be on the lookout for these children and should report them to the supervisor of such classes where there is one, or to the Board of Education. Private

physicians should be encouraged to report such children by the distribution of addressed postcards that can very easily be filled out and mailed.

This is the general procedure where there is well organized medical inspection in the school. Rural nurses and teachers have far greater responsibilities since it often devolves upon them to see that children with seriously defective vision are taken for correction or treatment to centers where they may obtain the advantages required. In communities where there are no sight saving classes every possible effort should be made to see that children with seriously defective vision obtain as many advantages for sight saving as can be offered.

Ten children in a community needing the advantages of a sight saving class warrant its establishment. Not more than four grades should be represented in any one class; one teacher can not be expected to do efficient work with a greater number of children since she must always bear in mind the object for which the class is established, to save sight while providing an education.

The children in these classes should be under the supervision of a skilled oculist who instructs the teacher regarding the amount of eye work each child is allowed to do, the difficulty from which he is suffering, the necessary precautions to be taken and the time at which he should return for treatment or reëxamination.

The school nurse can be of great assistance in interpreting these directions not only to the teacher of the class, but to other teachers of the school so that there may be an intelligent coöperative effort for the child's welfare. The nurse can also in visiting the homes explain to the parents the necessity of coöperation so that the great care given in the class room may not be nullified by home influences.

### *Practical Measures in an Ideal Sight Saving Class*

In an ideal sight saving class the exposure of the room is northeast so that the children may have the benefit of the morning sun and the steady north light for the rest of the day. The class room is of usual size because the eye troubles from which most of these children suffer are often symptoms of other difficulties and there must be ample room for them to move about or to change their desks from place to place so as to get the best light. Unilateral lighting avoids cross shadows; the glass area is one-fourth the floor area and the windows reach within six inches of the ceiling since the best light comes from above. Two buff colored shades of a translucent material are placed with rollers at the center of each window so that one shade may be pulled up and the other down, thus making it possible to diffuse the light without interfering with the ventilation. The walls are painted a light tan or buff and the ceilings are white, both in matt surface for the purpose of reflecting as much light as possible without glare. For use on dark days a system of artificial lighting is installed in which the light sources are covered by diffusing globes giving a maximum of light and a minimum of glare. These lights are controlled by two switches so that those farthest away from the window may be used alone if necessary.

Blackboards of good slate are so placed that it is never necessary for the children to face the light when looking at them and the boards are not placed near enough windows to reflect glare. The room is equipped with movable desks and seats of correct size—they are in dull finish so that there will be no reflections. The desks are adjustable so that they may be raised to an angle in order that each child may sit erect while working. Books are provided in 24-point type, printed in black ink on buff paper so that the child may read without eyestrain; there are large outline maps with no trying details in fine print; material for hand work abounds and a typewriter in large type is used as a medium for written expression.

Arrangements are made for a hot lunch for those children unable to go home at noon.

Children in sight saving classes are not segregated. It is essential for their mental and social development that they do as much of their work as possible with children of their own age, hence they go into the regular grade for oral work, rote singing, gymnastics and assembly periods. They go into their special room for eye work and for such reading by the teacher as it would be otherwise necessary for them to do for themselves; oral teaching is especially encouraged.

It will readily be seen that the expense of such a class is heavy. But it is not nearly so heavy as educating a child in a school for the blind or as allowing him to grow up to become a liability to the state. Since the state requires that every educable child shall be educated it should share the expense with communities. Hence in several states laws have already been passed providing *pro rata* or other appropriations for the carrying on of these classes.

*Results*

With the careful consideration that is given to the correct use of the eyes about 16 per cent of these children are able to return to the regular grade at the end of the first year; children who have become chronic repeaters are often found to have excellent mental ability when they are given the proper conditions under which to work, and children who might otherwise join the ranks of the blind in many instances have their sight saved.

Nor are the children alone benefited. Teachers who have found these children one of their greatest problems are relieved of having to devote an unfair amount of time to them; nurses are no longer worried with the fear that eyes of these charges are growing worse for they know that every opportunity is given them to grow better; oculists who have been at their wits' end to know what to do with children unable to use the regular school equipment find in these classes a solution of one of their many problems.

Thus the sight saving class has come to stay—it is the foster child of the state which must share the responsibility of helping him to outwit his handicap not only in order that he may grow into a useful citizen but that his eyes may behold the wonder and the beauty of the world about him.

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Sixty-one nurses planning to attend the International Council of Nurses in Helsingfors, July 20–25, had completed their bookings on the official steamer, the Caronia, early in March. First class accommodations on North Sea steamers from Hull to Helsingfors have been reserved for members of the official party sailing on the Caronia. Many communications have been received by the Transportation Committee from nurses sailing in advance of the Caronia on July 8th, asking to be assigned accommodation with the official party for the North Sea journey. This is a reminder that nurses sailing on the Caronia will have precedence over any American nurses who may happen to be in England, and those who sail in advance of the Caronia are urged to make suitable arrangements for reaching Helsingfors a few days in advance, otherwise there is a bare possibility that they may have to accept third class accommodations for the 48 hour journey.

We also recommend that steamer reservations for the return voyage be secured at the earliest possible moment, for these become increasingly difficult to obtain as the season advances. Therefore, please advise Thos. Cook & Son, 585 Fifth Avenue, New York, of the steamer, date and port of your departure for home that they may assist in the completion of your travel plans.

If there are any who have not yet made hotel reservations in Helsingfors, they are advised to communicate at once with *Committee on Arrangements, Kirurgiska Sjukhurst, Helsingfors, Finland.*

# MODERNIZING HEALTH CONDITIONS IN VENICE

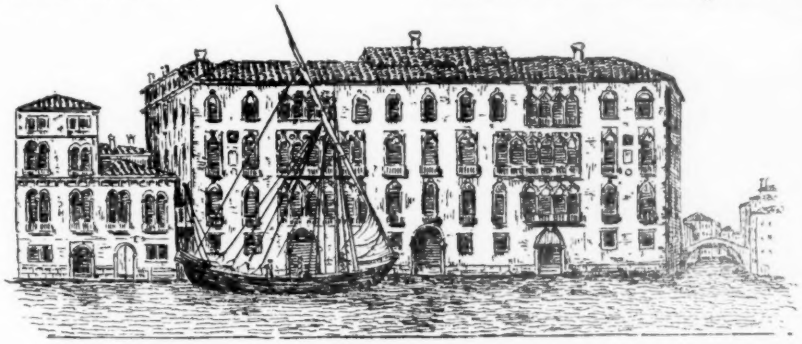
By Grace Baxter, R.N.

*Pen and Ink Sketches by the Author from the Originals*

IN a country where nursing is unfortunately still a sporadic development, it is surprising and interesting to find a city as public spirited as Venice has become, thanks to the practical efficiency of its Congregazione di Carità, which has in less than three years time coördinated all the philanthropic institutions of the town. The work done by this Charity Organization between February, 1921, and March, 1924, is described in detail in two pamphlets, and it is by no means negligible.

The first acts of the committee under Sig. Spandi were naturally of an economic nature, the war and the crisis which followed it having crippled all the city institutions, but an energetic reorganization of their budgets, reduction of superfluous personnel, and careful weeding out of the chronics, orphans, aged and mental deficients who were crowding all the hospitals, brought in an increase of income of over a million lire.

The next step was to clear out the unsanitary and antiquated Ospizi Sparsi, scattered hospices where the aged poor were housed free of charge. These were modernized on a large scale, made into dwelling houses, and turned over to the public, while their former inmates were received into clean and airy hostels attached to other institutions. The shortage of dwellings was further relieved by the construction of twenty-six sanitary houses for poor families on land granted by the city on the island of St. Elena. By express disposition of the city the charity organization was assigned the direction not only of the City Hospital but of the Tuberculosis and Infectious Hospitals, the Giustinian Memorial for chronics, the Pellestrina Hospital which is about to be turned into a convalescent hospital, etc. The committee, with at its head Sig. Spandi, the chief agent of this civil movement, next instituted public baths, planted gardens and orchards in all the available lands attached to the various institutes, provided courses for hospital patients in personal hygiene with lectures, posters, and moving pictures, started instructive milk stations, instituted summer outings for asylum



*Giustiniani palace; fifteenth century. Chateaubriand lived in apartment just behind the boat*

children, and outdoor schools for the convalescent children of the different hospitals, financed the workshops in the Workmen's Institute, and last but not least founded a School for Nurses with a Nurses' Home in the Hospital of SS. John and Paul, and a Home for Medical Students in the Civil Hospital.

In the city workhouse an artesian well has been sunk, and a model bakery opened, which supplies all the allied institutions, while in the Civil Hospital an ice factory now provides for the needs of the patients.

These are some of the chief results of an intelligent and up-to-date administration, in a young country which is forging a way for itself to the front. It is a pity indeed that the nursing situation, for a complexity of reasons, still lags behind in our otherwise far from backward Italy.

*Island of S. Giorgio Maggiore*

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## AMONG MIDWIVES IN TEXAS

*Abstract from narrative report by Lillyan P. Newsome*

*"Nurse Newsome" is the Negro nurse recently on the staff of the American Child Health Association. She is now continuing Midwife Supervision with the State Board of Health, North Carolina.*

Midwives are always afraid when we first go out to locate them. They seem to think we are trying to trap them and usually come out to meet us very much excited, and answer "No, ma'm," or "I don't know, lady," to every question asked them. But after attending one class they are usually glad to return, and often remark to outsiders, "Um guine to school now, honey, didn't you know it?"

The Bureau of Child Hygiene issues silver nitrate solution in wax ampules to all midwives in the state. When I asked one midwife at class how she used it, she replied, "Well, nurse, I puts it in a pan and I melts it, then I strains it and lets it cool, adds a little water to thin it down, then I pours it in baby's eyes and I tell you it makes them just as clear as a crystal."

Of course this midwife is illiterate. There were many others of the same class who had never heard of birth registration.

I tried to call a little meeting for prenatal cases, but all in vain. The mothers refused to come out, said they were afraid and ashamed, for I might send them to a doctor, so I had to make home visits.

*Some Superstitions Still in Vogue*

**To Check Post Partum Hemorrhage**

(a) Take some warm ashes and salt and slap to patient's stomach (make into poultice).
(b) Take sugar and sweet oil on a rag and slap to patient's abdomen.

**For After-Pains**

(a) Put a razor under mattress to cut off pains.
(b) Get a thorn bush the length of bed and put by the patient's side.
(c) Make an "x" cross mark with patient's shoes.

**To Start Up Labor Pains**

(a) Make tea out of red-oak bark and alum and give patient to drink.
(b) Warm water to drink with a few drops of turpentine and add a little quinine.
(c) Make tea out of dirt-darbow nest (a dirt-darbow is a kind of bee) and give patient tea to drink.

# SHOULD NURSES DO INTELLIGENCE TESTING?

By Frankwood E. Williams, M.D.
Medical Director, National Committee for Mental Hygiene

THE answer to this question is the same as might be given to several other similar questions. Should a nurse give anesthetics? Should she do Widal tests or Wassermann tests? The answer would seem to me obvious—if she is specially trained to do any of these things there is no reason why she should not do them; if she is not specially trained—no. All of these matters—including intelligence testing—are matters of expert procedure. There is nothing in her training as a nurse that qualifies her as an expert in any of these fields. Should she wish to qualify for such work there is only one way in which she could do it, and that is by special additional training.

The method of testing looks easy. Any intelligent person, it would seem, should be able to ask a series of questions and record the answers. The intelligence test, however, is a highly technical procedure. No one, whether nurse, doctor, social worker, or school teacher, should be permitted to use them unless they have been technically trained in the use and interpretation of the tests. A few lectures on the theory or use of the tests qualifies no one for such work. Training under supervision is necessary.

The intelligence tests when properly used are instruments of much importance. Any individual well trained in their use and interpretation can throw a very considerable light upon problems with which nurses, teachers, and social workers are wrestling. Those most expert in their use, however, know of the many pitfalls that must be avoided, of the serious mistakes it is easy to make, both in the giving of the tests and in their interpretation, of how relative any judgment drawn from them must be, and of the inadequacy of the tests alone as a diagnostic measure. It is only the untrained novice who is sure she can easily select the feebleminded in a school group, for example, by the use of such tests. Her result will indeed show that certain pupils are "feebleminded" if any one wishes to accept her results; they will also show that—not intending to be so at all—she is a dishonest person in that she has attempted to do—with the best intentions in the world—what she is not prepared to do, and through her own incompetency has placed a label that bears serious implications upon a pupil who may not be feebleminded at all. Even assuming that the test has been properly done and that the intelligence quotient is found at the level assigned as "mentally defective," the determination of this I.Q. is not the end of the matter; it is the beginning. There are a number of conditions besides feeblemindedness which may return this I.Q. A differential diagnosis as between these several possibilities is necessary, and this differential the nurse is not prepared to make.

One either can do these tests or one cannot. There is no halfway ground. One cannot do them "fairly well." One would not think of doing a Widal test "fairly well." One either is competent to do a Widal or one is not. Of what possible value would a Widal be by one who has had a "little experience" and can do it "fairly well." Such a situation would be absurd. Intelligence tests are expert technical procedures that one is competent to do or one is not. To become competent a definite course of instruction and work under supervision is necessary. If one has not had this one is not competent.

One wishes that every school child might be examined by persons qualified to make these examinations in order that schools could be properly graded, that those with superior abilities might

have the opportunity to progress as they should, that those with lesser ability might be permitted to work at a pace suitable for them, and that those who rate low in intellectual capacity might be identified early in their school careers so that proper medical and educational provision could be made for them. Aside from the classroom teacher probably no one is more aware of these needs daily than the social worker and the public health nurse. Called upon by the teacher to assist in her problem, deceived by the harmless appearance of the intelligence test blank, the nurse in her good will, and with a spirit of helpfulness, has in many instances responded. This is unfortunate. It carries with it the possibility, in fact the certainty, of great harm.

To label a child mentally defective under the best circumstances of accuracy is a serious matter. Where it is done with accuracy it is a kindness, to be sure, for now the child will be better understood, and there will be required of him, if those in charge of him are wise, only those things which lie within his capacity. Where it is not done accurately (and again, it either is or it isn't; there is no half way) it is a tragedy. Instead of being better understood, he is more misunderstood. The treatment that follows is the wrong treatment. Treatment that he requires is withheld while the treatment that is forced upon him does not meet his need. (Treating a patient for pneumonia because of the pain in his chest serves no useful purpose when the patient really has appendicitis.) And what is more, if this label is placed upon him by the school system, or by an otherwise reputable and respected nursing agency, that label sticks. Ten years later a need arising for knowledge of the school record in a matter of employment, for example, the record will show that as a result of an intelligence test (presumably well done, and taken now at its face value, even though the nurse who made it may have had many misgivings at the time) the boy was considered mentally defective. That will close many doors to him without further consideration.

A nurse may say, "But there is no one in my entire district who can give the test." Very well; that is unfortunate, but if it is a fact it must be faced as such. It does not justify one in attempting to do what one is not oneself prepared to do.

Great as the need may be, there is only one thing to do—wait until someone in the district prepares herself to make such tests, or until someone from outside the district is employed to do the work. If the physician or nurse on the staff of the local hospital who is skilled in reading X-ray plates resigns his position, another without any special knowledge of these matters would not be justified in saying, "Well, I don't know much about it, but I'll do the best I can." If there is no trained person available an X-ray examination can not be made in that hospital, unfortunate though that may be. Of how much help would this novice's "best" likely be? Is one justified in placing a patient's leg in a plaster cast, or keeping it out of it, as the case may be, because this well-intentioned but untrained person decides that an artifact which he does not know how to interpret, is or is not a fracture? There are degrees of skill, to be sure, both in the reading of X-ray plates and in the giving of intelligence tests, but there is a minimum degree of experience below which no one is justified in doing either.

The minimum, so far as the intelligence tests are concerned, is a course of training which embraces a series of examinations under close supervision. When the student leaves such a course she will have little enough skill. It is a question whether she is prepared even at this point to do independent work. A period of work in a well-organized clinic where her procedure and interpretation would still come under some supervision, would be none too much. At least we can be sure that without this preliminary supervised training she is not prepared at all.

# GROUP INSURANCE

By Philip H. Welch
Metropolitan Life Insurance Company

Editor's Note: We hope to begin in an early number a discussion in the Department on "Policies and Problems" on accident and sickness insurance as applied to public health nursing services.

PUBLIC health nurses and other practical social workers have a powerful friend and ally in the comparatively recent institution of group insurance. The elementary economic and insurance facts involved are, therefore, worth reviewing.

There has been a lot of sympathy wasted, time out of mind, on a certain old woman heavily encumbered with children. She is easily identified by the fact that she lives in a shoe. It seems to me she has a pretty easy time of it. From personal observation over a period of thirty years, since I first had knowledge of this particular family, I know that none of the children is a day older to-day than he was thirty years ago. Think how this simplifies the old lady's task. By this time she must be able to spank them all soundly and put them to bed automatically.

This is the basic idea of group insurance. The employer is the old woman who lives in a shoe. His employees never get any older. While the individuals may age perceptibly with the passing of years, time writes no wrinkles on the average brow. The mystic person known as the "average man" grows a little older year by year with a young concern, but when he has reached a certain age, say thirty-one or two, he stays there and becomes stationary. Thus it is possible for the insurance company year by year to insure the whole group at the short term rate for this average worker's age.

The extraordinary advantages of the plan are so evident that in the majority of instances the workers have readily come forward to ask their employers that they be permitted to buy for themselves through the employer the same amount of this inexpensive insurance as the employer gives them free, thus doubling the protection for their families. This is what is known as "contributory group life insurance" and is rapidly becoming the most popular sort. In these cases the worker and his employer divide the cost of the insurance between them.

There is one highly significant feature about group insurance which in a measure explains its cheapness: it is dependent on the fact that the insured is employed with the firm taking it out. If he leaves the firm, he leaves the insurance also.

Naturally he will hesitate about quitting his job for a trifling cause. Anything which tends to keep men from shifting their jobs is of utmost importance to employers. Group insurance would only have to help cut down the labor turnover of a given plant a comparatively small percentage and it would pay for itself.

Years ago industrial units were so small that the majority of the employees knew the boss personally. Nowadays, as often as not, the employer is seen by the employee once or twice a year. Combinations have revolutionized the character of industrial establishments. The "personal" relationship has been supplanted by the "personnel." The human equation has become algebraic.

It is difficult not to be loyal to an individual you respect and of whom you see a great deal; loving a corporation to death is another matter.

The human factor comes back into view again with the advent of group insurance, but in a new way. The worker's home is of sufficient importance to the employing organization for

them—though perfect strangers—to contract with an insurance company to stand ready in case of disaster to ward off the blow. This is no philanthropic paternalism, but a hard-headed business proposition. The employer gives official recognition to the cockles of the heart; those cockles must be warmed just as surely as the ingots of metal in the foundry.

Not so many years ago the speed-up, efficiency expert was introduced into the business menage. For a little while he increased output and made a great hit; then one day he tried to explain to a workman how he could save motions and get more done and the workman said, "Aw, have a heart," and that was the end of the efficiency expert.

Employers have seen the light. They have discovered that the employee is not a statistic but a person. The new vision inspires the employer who takes out group insurance, it inspires the employer who provides a plant physician and nurses to look out for the health of his men. The salvation of our industrial life lies in this new vision, which is just as little appreciated by an employer who prates about patronizing the worker, as it is by the theory-ridden radical who sees a menace to the freedom of the individual. The new vision is just plain common sense.

So far, we have let you off easy on the technicalities of group insurance.

### *Some of the Technicalities*

The insurance laws stipulate that a group life insurance policy must cover the employees of one employer. There must be at least 50 employees for an employer to take out a group life insurance policy. The beneficiaries are named by the employees and almost always are wives, children or other close relatives or dependents. The insurance becomes payable either in the event of the death of the insured employee or in the event of total and permanent incapacity incurred before the age of sixty. Group life insurance has no connection with and in no way affects Workmen's Compensation Insurance. It means additional insurance.

The law also provides that there can be no discrimination between individual employees except such logical selection as is based on a prearranged schedule. For instance each employee of less than a year's service may get $1,000 insurance which is increased $100 for each extra year until a maximum of $3,000 is reached. This is a common schedule. Another widely used schedule is to give each employee insurance in an amount equal to his yearly salary. Some group contracts call for the same amount of insurance for all employees.

Group life insurance is issued to all employees without a physical examination. This is possible because of the fairly good condition of our old friend, Mr. Average Man. The waiving of the examination means that about 15 per cent of those insured under group contracts are getting the only kind of insurance they could get anywhere. They would be rejected as individuals because of their inability to pass physical examination or because of age.

It is for this reason that under the contributory plan it was found necessary to stipulate that 75 per cent of all the eligible employees must apply for the insurance before the blanket policy could become effective. Otherwise the lame and the halt and the aged could apply in large numbers while the physically fit, the "good risks," might let it go by default.

If any employee leaves the company he cannot take his insurance with him, but he can have it converted to any type of individual insurance he desires, paying the rate for his age at the time of conversion. This conversion takes place without physical examination also, and thus enables many men to get insurance to which they would not otherwise be eligible.

There are several outgrowths of group insurance which are logical applications of the principles of different sorts of ordinary insurance to the group idea. Applying the endowment insurance idea, for instance, we get a

system of insured thrift which enables the employee to save money at the same time he is being protected.

Blanket policies are issued also for protection of the worker against loss of time due to sickness or accident; a group pension contract will provide employers with the simplest, most flexible pension plan that has probably yet been devised. The sound economics of doing business wholesale is as evident in the insurance business as in any other line.

All these matters are important because they are as interesting to the worker's wife as they are to him. According to James E. Kavanagh, second vice-president and head of the group division of the Metropolitan Life Insurance Company:

> The most intimate thing in a man's life is his love for his family. If this love is tied up with his work-a-day life, then a big step has been taken in the direction that tends toward greater labor stability and greater individual efficiency and happiness. Group life insurance is a direct means to this end. It is protection for the worker's wife and children through the business that gives him his daily bread. The psychologist probably would describe it as a matter of connecting up the brain centers that function during his working hours with those that come into use when he thinks of his home and family.

And this brings us to the subject of nursing which at least one of the large insurance companies includes in the contract. Industrial nursing has taken on a new lease of life contemporaneously with the spread of group insurance. There may be a cause and effect relation, but it is probably more accurately explained by the fact that the employer sufficiently interested in protecting his workers' families is also likely to be interested in protecting his workers' health.

Some sort of nursing service, whether provided by the insuring company or secured by the employer by separate contract with the local nursing organization, has been found to be of very definite value. It is popular with both employee and employer as evidence that the latter really has a heart. The nurse advises the employer if the employee needs more than medical assistance. The employee comes back to work sooner and much more fit, both physically and mentally, as the result of the nurse's attention.

To quote Mr. Kavanagh again:

> Business men are coming to realize that one of the strongest factors in determining the attitude of the public toward a given concern is the attitude of the employees toward it. The public knows the institution through the employees with whom it comes in constant contact. As a man is known by the company he keeps, so is the company known by the men it keeps.

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## SONG

April, April,
Laugh thy girlish laughter;
Then, the moment after,
Weep thy golden tears!
April, that mine ears
Like a lover greetest,
If I tell thee, sweetest,
All my hopes and fears,
April, April,
Laugh thy golden laughter,
But, the moment after,
Weep thy golden tears!

*William Watson*

# TWO NOTABLE ANNIVERSARIES

## THIRTY-FIFTH ANNUAL MEETING OF THE VISITING NURSE ASSOCIATION OF CHICAGO

By Julia MacNeil and Phoebe L. C. Swenson

IN December, 1890, the first Annual Meeting of the Visiting Nurse Association was held. During that year four nurses made 8,586 visits to 771 patients.

On January 15, 1925, the thirty-fifth annual meeting was held in the Crystal Ballroom of the Blackstone Hotel. Mrs. Joseph M. Cudahy, the beloved President of the Association, was in the chair. The Directors, friends, and nurses listened to the different reports with eager interest. During the year 255,080 visits were made to 49,248 patients by 104 nurses. Reports were read by the following: Mrs. Joseph M. Cudahy, President; Mrs. A. H. Wolf, Treasurer; Miss Edna L. Foley, Superintendent; and Miss Jessie L. Stevenson, Supervisor of our Infantile Districts, whose subject was "Chicago's Crippled Children." Miss Stevenson gave a summary of the service for which she was released to the Chicago Community Trust for six months. This service was paid for by the Rotary Club, the whole arrangement making an excellent piece of local coöperation.

Stereopticon pictures showing the type and character of the work were shown by Mrs. Uri B. Grannis, the Recording Secretary, who takes these pictures each year.

The program was short, a brief hour in length, but all who were there felt the thrill that comes from great work done, and were filled with a desire to do even more and better work the coming year.

Honor pins, tiny replicas of the beloved V.N.A. pin, were awarded; gold and blue to Rose Collins, one of our supervisors, for ten years of service; silver and blue pins to Eva Crepeau, Gertrude Osborne, Rebecca Cohen, Vivian Vaughn and Mrs. Edna Quinsler for five years of service.

*Miss Foley writes:*

This poster, used in the Association publicity, occupies a place of honor in the headquarters office. It was painted by a local artist for the Chicago Child Welfare Exhibit in 1911. The tenement background, it is hoped, will eventually become a thing of the past, but at the time this poster was painted, one of the Visiting Nurses had just succeeded in making a back porch on just such a tenement into the first playground known in our big steel district in South Chicago. It was called "Tinkie Porch" and led to the opening of a very well-conducted vacant lot playground, also under the auspices of the Visiting Nurses and the steel mills.

When the poster was painted, the Visiting Nurses, and in fact most of the graduate nurses in Chicago, wore veils. The veil retained its popularity in Chicago long after it had died out in practically every other city. The bonnets were fearfully uncomfortable, however, and offered absolutely no protection from the sun in the summertime.

In the evening the Directors gave a dinner for the nurses at the Young Women's Christian Association. The dinner was a strictly family affair and was delightfully informal.

An unusual feature of the dinner was the attractive place card printed by one of our patients, a boy of sixteen years. This patient had a daily dressing by the nurses at his home for about two years. Later, he was sent to the Fallon School for Crippled Children where, with his other studies, he is learning printing. The money earned on the card goes towards a printing press which he hopes to use when he starts in business for himself this year.

Another crippled boy made the stamp for the cards by copying the design from a V.N.A. pin. This stamp (reproduced at the beginning of this article) was made in spare minutes during recess, and was given to the association as a gift.

The cards were carried out in V.N.A. colors, blue and white.

## TWENTY-FIFTH ANNUAL MEETING OF THE PROVIDENCE DISTRICT NURSING ASSOCIATION

ALL things are relative. The Providence District Nursing Association in celebrating this year its twenty-fifth birthday has a feeling of maturity, not to say downright old age. Yet Providence has but to look forty miles across the narrow confines of Rhode Island to find that the Boston Association can boast thirty-nine well spent years, and this very year the Chicago Visiting Nurse Association has reached the (for this country) ripe old age of thirty-five. Such anniversaries make excellent points at which to pause for a moment in the midst of the busy life of our organizations that we may look backward and take account of stock, and forward to the possibilities of the future.

The poster which this small cut inadequately represents was made in 1914 for the Providence District Nursing Association by Mrs. Maginel Wright Enright, as a Donation Day poster. It was reproduced in colors and used as stickers and for various other publicity purposes. It presents with rare sympathy the extremes of life and embodies the motto of the Association, "That no human being shall suffer or die neglected in any nook or corner of Providence."

The beautiful original water sketch, donated to the Association by Erling Ostby, one of the Directors, was presented to the National Organization for Public Health Nursing, together with a complete set of plates, in 1915, and now hangs in the office of the Directors.

In Providence there was perhaps nothing more indicative of the place the Association has grown to take in the community than the dinner which marked the birthday. At it were gathered more than two hundred and fifty men and women representing the best of the city's life. A Chief Justice of the Supreme Court of the State of Rhode Island (seventeen years President of the Association) was toastmaster, and at the speakers' table were gathered, beside the Mayor of the city, representatives of the City Health and Poor Departments, Superintendents of the Hospitals and Training Schools, representatives of the Medical Association, together with notable lawyers, clergymen, and citizens of the city. The story of the twenty-five years of the Association's life was told by the Director and the Associate Director whose experience stretched back into the past, for each has seen respectively twenty and twenty-one years of service. The nurses themselves, over fifty strong, added to the festivity by singing rounds between the courses.

The founder of the Association was present, Miss Eleanor B. Green, who a quarter of a century ago, in her visits among the poor, was the first to feel the need of skilled nursing, and who not only set the ball rolling which resulted in the present organization, but who has served the organization continuously through all the intervening years. There were also present two other members of her original committee of six, both still members of board and committees, and greatly to the delight of everyone the beloved first nurse, Ella Kenney, now Mrs. Ruby, came on from Washington to help celebrate the day.

The story of the Organization's life and achievement told in duet by the Director and Associate Director was much the same as that which might be told of any public health nursing organization. It was a record of the steady growth of public confidence and the increasing demands of the patients themselves, of the abandonment of the purely charitable basis on which most of the early organizations were founded and the reaching out of the service to all, of increased efficiency of the staff, and its growth from a single nurse in 1900 to its present size in which fifty-two graduates and eight undergraduates are daily in the field, of many pieces of work developed beyond the recognition of this Organization, of many others started and turned over to other agencies. All this is too familiar to public health workers to require repetition, but a stranger from another city felt that the attitude of the city officials toward the Organization was original and could only portend the millennium. The Superintendent of the Health Department and the Overseer of the Poor in their speeches recapitulated, not merely the achievements of the nurses, but each at some length spoke of the amount of money saved for the city by the work of this private Association, and both announced that though unable to secure their own budgets they felt that the city should increase the present subsidy of the Association as a mere matter of justice and as a recognition of important results.

Perhaps, however, the highest note of the evening was struck by a well-known Providence lawyer who announced that he represented the average man in the street. After speaking of what he felt that the Association meant to the citizens of the city he said:

> We frequently hear that in the eyes of the Japanese the war has greatly lowered the prestige of Christianity because of the powers of hate and cruelty released by Christian people.
>
> If this is so there must be a converse truth in the effect on any community of such an organization as the District Nursing Association which carries throughout a city that spirit of helpfulness, kindness, and service which is the very heart of the Christian religion.

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The first permanent molar is really the most important tooth in the mouth. Every physician, nurse, welfare worker, governess, and mother should be informed on the significance and function of the first permanent molar. No mouth is ever perfectly normal when this tooth is lost, and yet through the peculiar circumstances attending its eruption it is more frequently neglected and more prone to decay than any other permanent tooth.

Aside from the fact that it is one of the most effective masticating teeth in the mouth, it has a special function which is never realized by the laity and not always by the profession. It is the real standard-bearer of the dental arches during the developmental period when the deciduous teeth are being lost and the permanent teeth are taking their places. It is the one tooth to held the jaws the proper distance apart while the child is erupting the permanent teeth, and if this tooth is lost early in life it invariably causes a dropping together of the two jaws, resulting in a serious impairment of the contour and character of the face.

Everyone who has anything to do with the rearing of children should watch for this tooth, which comes in at about six to seven years of age, and if the slightest cavity appears it should be filled at once, and the tooth preserved at no matter what sacrifice of time and energy.

*From "Dental Hygiene for the Child," by C. N. Johnston, LL.D., D.D.S., Published in The American Journal of Public Health, February, 1925.*

# PROBLEMS IN ADMINISTRATION OF WELL BABY CLINICS

By J. H. Mason Knox, Jr., M.D.
Chief, Bureau of Child Hygiene, State Department of Health, Maryland

This is the fourth paper in the series on Well Baby Clinics. The first, by Mary V. Pagaud, appeared in the January number. The discussion in February was by Borden S. Veeder, M.D., in March by Dorothy Deming.

THE problems raised in connection with the "well baby clinics" by Miss Pagaud are most pertinent and must be fairly met if the clinics, or, as we prefer to call them, conferences, are to be a success. I think we must differentiate between regularly organized conferences in an urban community and those in a rural district, at least in regard to the attitude of the medical profession.

In our experience in Baltimore, we have had practically no opposition from the general practicing physicians. They are usually consulted as to whether or not a conference for babies or young children would be useful in their neighborhood and they are always asked to be present when they can. However, we have found from experience that the conferences are best conducted by a group of young men who have had very much the same pediatric training, and generally, who do not live in the neighborhood of the conference.

1. *What income limit, if any, should be adopted for patients attending a well baby clinic?* We have found it impractical to make hard and fast rules. The conferences are intended for those children whose parents cannot afford to take them regularly to their doctor. We find that the nurses, on their visits to the homes of the patients, quickly detect imposters. In the twenty years during which the clinics of the Babies' Milk Fund Association have been in operation, I can recall no instance where a practicing physician objected to the work of the conference in his neighborhood. Scrupulous care is taken, of course, to limit the activity of the conference to the care of well children. Sick children are referred to their own physician, or if there is none, to the operating hospital clinic.

The conference receives border-line cases, that is, children of parents of moderate income, but in these cases especially it is careful to refer a child to its own doctor for any indisposition. There is an opportunity, also, for a free-will gift on the part of the parents toward the work of the conference. It seems to us that the good will of the physicians in the neighborhood upon whom the mothers are dependent in cases of illness is the most indispensable factor in the success of a child health neighborhood conference.

2. *How shall the financial status of the parents be determined?* It has already been indicated that in our experience the questioning of the mother supplemented by a visit to the home is sufficient to determine this question.

3. *When shall prescriptions be given in a well baby clinic?* These are practically never given. Children with a common cold, which in the opinion of the physician requires a prescription, are sent to the family doctor or to the hospital clinic.

We agree with Miss Pagaud that it is practically impossible to draw a line between various degrees of illness.

4. *Shall physicians in charge of well baby clinics accept clinic patients as private patients if illness occurs?* The answer to this question would be emphatic. No. If the mother does not have confidence in her family physician, she can be advised as to a change, but to permit the conference physician

to become the family physician in case of illness must, of necessity, arouse the opposition and ill-will of the family's physician.

In the establishment of child health conferences in rural districts, after a number of changes, it has seemed wise, at least in Maryland, not to have conferences at weekly or even monthly intervals in the same towns, but to hold these conferences at various points in a county, returning to the same place perhaps three or four times a year. In other words, the conferences are used primarily to call attention of parents to the importance of routine examination for well children and in this way care is taken to avoid having the parents look upon the conference for care of their children but to depend, for this purpose, upon their family physician.

Between the county conferences the nurses frequently hold "baby weighings" at which times the mothers bring their children for inspection and weighing by the nurse, who refers all cases not gaining satisfactorily to the family doctor. By this means a larger proportion of children in any one county comes into contact with the conferences, and more well children and children with minor illnesses go to their family doctors than would do so without the influence of the conference. Consequently the rural practitioners are stimulated to more activity along preventive lines.

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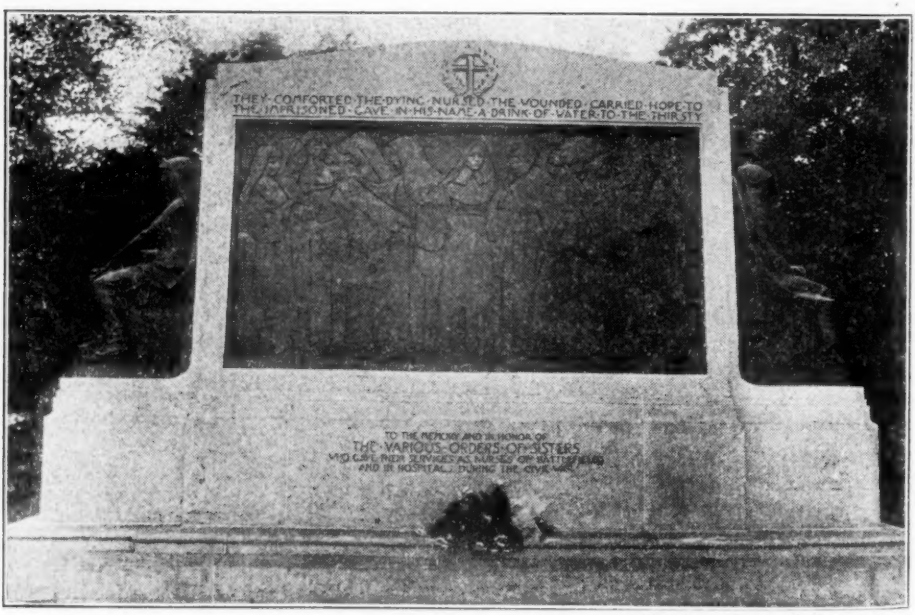


*Courtesy, Hospital Progress*

"Deeds of sacrifice of long dead heroines of the battlefield" are commemorated in the monument to the memory and honor of sister nurses of the Civil War erected in the embassy district in Washington, D. C. On the bronze panel are portrayed in bas-relief twelve members of the nursing orders who cared for the sick and wounded in the war of 1861.

The idea of this memorial was conceived in 1914 by Mrs. Ellen Ryan Jolly, LL.D. President Wilson signed the joint resolution which was later introduced into Congress.

# YOUTH OF THE WORLD

*Illustrations, courtesy of the American Red Cross*

The Junior Red Cross, a league of the youth of the world, is now organized in approximately thirty-five countries and numbers more than seven million children in its membership. It has been advancing steadily in membership and influence since 1918.

During the past year, Miss Anna Milo Upjohn has been touring the world as a sort of Ambassador Extraordinary of the six million school children of the United States who are members of the Junior Red Cross.

Miss Upjohn is an American artist of note who has devoted herself to the service of the Red Cross for the past seven years, aiding in Europe during the World War and since the Armistice as an enthusiastic advocate of the Junior Red Cross. Immediately after peace was declared, she visited all of the countries in Europe where the American Junior Red Cross carried on educational relief for the children of the war devastated regions, and her sketches and drawings illustrating child life in those sections were widely used.

A year ago the American Red Cross commissioned Miss Upjohn to make a tour of the world in order that she might sketch the children of all countries having a Junior Red Cross society and write about them for the benefit of the girls and boys of the United States. Her tour has carried her to Hawaii, the Philippines, Japan, China, Siam, Esthonia, Latvia, Lithuania, the Balkan States and all of Central Europe.

*Going to Market—Montenegro*

Travel in Europe is still difficult and Miss Upjohn experienced many hardships but she returns to America thrilled with the things she has seen that prove how thoroughly the leaven of the Junior ideals is working. Her

brush and her pen will be busied for many months to come transmitting to the school girls and boys of the United States the messages for them committed to her care by children around the globe and in acquainting them with the fact that when they know more intimately these young people of foreign lands they will find much in common upon which may be built a lasting structure of understanding and friendship.

*The Boy Weaver—Palestine*

*Forest Devotions—Czechoslovakia*

# EDUCATIONAL FACILITIES FOR COLORED NURSES AND THEIR EMPLOYMENT*

*Abstract of Informal Study*

THE Hospital Library and Service Bureau of the American Conference on Hospital Service last year undertook an informal study to determine what accredited schools of nursing admitted colored students. At the same time, the Bureau gathered information—unavailable through other sources—on colored nurses employed in hospitals, in private duty, and in public health. The information was collected by sending questionnaires to the 1,696 schools of nursing on the 1922 list accredited by the State Board of Nurse Examiners and published by the American Nurses Association; to 160 institutions reported to be hospitals for the colored not on the accredited list; to 48 State Boards of Nurse Examiners; and to 933 state, county, and city health officers. Information was also sought from national nursing and welfare organizations.

The twenty states having one or more schools admitting colored students are:

| | |
|---|---|
| Alabama | Massachusetts |
| California | Mississippi |
| District of Columbia | Missouri |
| Florida | New York |
| Georgia | North Carolina |
| Illinois | Pennsylvania |
| Indiana | South Carolina |
| Kansas | Tennessee |
| Kentucky | Virginia |
| Louisiana | West Virginia |

Of the 1,688 accredited schools reporting, 54 admitted colored nurses. Of these 54, 25 were schools of nursing connected with hospitals for the colored or with departments for the colored in hospitals maintained by municipalities. Of the 55 replies from the 160 institutions reported as hospitals for the colored 21 indicated that they admitted colored nurses. Four of these 21 schools are now on the 1924 accredited list. Thus, there are 58 accredited schools of nursing in the United States admitting colored women.

### *Colored Nurses in Public Health*

The Hospital Library and Service Bureau also sent 933 questionnaires to a list including state executive health officers, full-time county health officers and city health officers in cities of 10,000 or more population. Of the 548 replying, 59 reported that colored nurses were employed. The question as to whether there was a demand for colored public health nurses was answered by 156 health officers. Of the 156, 132 answered that they believed that the supply was sufficient to meet the demand, 24 believed the demand was not met. Eighty-one said that due to the small number of negroes in their communities there was no need for colored nurses.

In addition, questionnaires were sent to some of the larger visiting nurse associations both in the South and in the North which were reported as employing colored nurses. Of the 22 replying, 21 believed that there was a sufficient number of colored public health nurses to meet the demand. All expressed satisfaction with the services rendered by these nurses. Nine thought that colored nurses were preferable to white nurses for work among negroes. Statements were also made in some of these replies that white people objected to receiving the services of colored nurses. Bettie W. McDanald, Superintendent of the Louisville Public Health Nursing Association, commented on this topic as follows:

* Copies of the general summary of the report will be sent on request to anybody engaged in hospital or public health work. Hospital Library and Service Bureau, 22 E. Ontario Street, Chicago, Ill.

I am not sure that I am altogether orthodox in my attitude. From a theoretical point of view, I believe that we should stimulate an interest among the colored people for service in their own group but in the practical working out of this situation, I cannot see that a better contribution is made (up to the present) by the colored nurses to their group than is made by the white nurses and I would hesitate to say that I feel they are preferable. My reason for saying this is that the *type of training* the average colored nurse receives in this part of the country is far inferior to that given to white nurses. Even the best training for colored nurses hardly approximates the poorest training given to white nurses. From another standpoint their educational background is not so good. Therefore, I think the type of service rendered would necessarily be of lower grade than under the other circumstances. In this answer I have not questioned the spirit of the service and I again emphasize the fact that I feel colored people should be encouraged to have a greater interest in and more opportunity to care for their own people and I do feel that *the type of training given should approximate as far as possible that given to the white nurses and the same standard should be required of them that is required of the white nurses.*

The numbers in the following table represent the colored nurses under both official and non-official administration. In reading this table it should be remembered that 41 per cent of the health officers to whom questionnaires were sent did not reply, and that therefore these figures cannot represent the total number of colored public health nurses employed in the United States.

*The Twenty-six States in which Colored Public Health Nurses Were Employed, and the Number in Each State*

| State | Number of colored graduate nurses |
|---|---|
| Total | 220 |
| Alabama | 14 |
| Arkansas | 2 |
| California | 2 |
| Connecticut | 3 |
| District of Columbia | 8 |
| Delaware | 2 |
| Florida | 7 |
| Georgia | 11 |
| Illinois | 23 |
| Indiana | 3 |
| Kansas | 13 |
| Kentucky | 3 |
| Louisiana | 1 |
| Maryland | 8 |
| Michigan | 5 |
| Mississippi | 1 |
| Missouri | 13 |
| New Jersey | 6 |
| New York | 24 |
| North Carolina | 11 |
| Ohio | 10 |
| Oklahoma | 2 |
| Pennsylvania | 3 |
| South Carolina | 2 |
| Tennessee | 15 |
| Texas | 8 |
| Virginia | 20 |

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## ONE HAIR-CUT

Jimmy, aged nine, had injured a finger. The visiting nurse of the district arranged to take him in her car to the dispensary for treatment. With the strange heroism children sometimes display Jimmy bore silently the removal of the nail with no anesthetic, and the painful dressing. On their way home, the supervisor, feeling that some acknowledgment of his gallantry was due said, "Jimmy, is there anything you would like specially to have?" Jimmy was silent a moment or two, then looking with bright expectant eyes at his friend replied, "If I could have a hair cut from a real barber, that's what I want most of anything," adding in explanation, "my dad always does it."

"Of course you can" said the supervisor, and steered her Ford towards the nearest barber shop. Jimmy grinned in perfect bliss above the swathing towel, and the barber at a quiet hint from the nurse went through all the luxurious motions demanded by the older members of the male sex when indulging in what the mere female of the species innocently believes is a simple process.

When, clipped, massaged, perfumed and brushed Jimmy again entered the car, he held his cap under his arm. It was a bitter day and the nurse expostulated. But Jimmy pleaded, "I want the fellers to see me—never had a real man's hair cut before—Gee, they'll think it's swell." Reluctantly feeling her responsibilities the nurse insisted on the cap being donned—yielding, however, to Jimmy's earnest, "Anyway, can't I take it off when we get to my street?" Arrived there off came the cap, Jimmy sitting proudly in the car accepting with outward calm the astonished glances and admiring jeers of the

*Contributed by a Philadelphia Visiting Nurse*

# COLLECTION AND PRESERVATION OF BREAST MILK IN BOSTON

*Together with a Brief Account of Preserving Milk by Drying* *

By Paul O. Emerson, M.D.
Boston Floating Hospital

FOR the past fourteen years, human breast milk has been collected for the Boston Floating Hospital under the supervision of Miss Martha Stark. She began to collect it in 1905 at the request of three physicians in Boston who used it in the treatment of gastric ulcers in adult patients for perhaps six months. About 1909 she began to collect milk for the Boston Floating Hospital and still supervises the system which she initiated. From her wide acquaintance with obstetricians and nurses, both in hospitals and out, she learns the names of mothers recently delivered. If they agree to give their milk to the Boat or to sell it, a Wassermann test is done on the blood, the family doctor's opinion is obtained as to freedom from tuberculosis, their children are inspected as to their condition and health and the state of cleanliness of the homes is taken into account. Every day one of Miss Stark's nurses goes to the homes for the milk and leaves a number of sterile bottles to be used in the collection of the next day's supply. The manual method of expressing the milk is taught the mothers now, where formerly the breast pump was used. The nurse places the filled bottles in a bag containing an ice bag and transports them to the pier where they are placed in an ice box. If more than one home is visited in the neighborhood, the supply from one home is left sometimes on the ice in the soda fountain in a neighboring drug store with the consent of an obliging clerk, until the nurse visits another home and returns. If the mother has no ice box herself, she is taught to make an ice container by the use of a large bucket lined with asbestos and containing ice in which a smaller receptacle containing the breast milk is placed. The largest amount we have obtained daily from one mother is seventy-two ounces and she regularly provides us with sixty ounces. Part of the milk we use is purchased from the Wet Nurses' Directory.

Since 1922 we have been preserving human milk by means of drying it on a small roller drying machine. The machine has been perfected gradually and each summer a small number of babies have been fed on dried human milk. We have had very encouraging results indeed which are soon to be published. We believe that a means of preserving human milk is valuable because in this way, we can store milk at times when there is an oversupply. It affords a means of easy and safe transportation to some distance in times of emergency.

* See "Collection and Distribution of Breast Milk," January number, and "Further Notes," March number.

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If we continue to use (and it is almost impossible to avoid using) the term fatigue in industrial conditions, let us remember how complex is its character, how ignorant we are of its full nature, and how impossible it is in the intact organism to distinguish lower from higher fatigue, to separate the fatigue of explosive acts from the fatigue of maintaining attitudes, or to eliminate the effects of changing interest, excitement, suggestion, and the like. In industrial psychology, our hope lies rather in the study not of fatigue tests but of the curves of actual output, endeavoring to analyze the various influences at work and to observe, by the comparison of curves obtained under different conditions, how industrial efficiency may be improved.

From "The Study of Fatigue," by Charles S. Myers, Director of the National Institute of Industrial Psychology of Great Britain—published in *Journal of Personnel Research.*

# POSTURE AND WORK

EDITOR'S NOTE: We print this brief article as an appropriate follow-up to "The Recognition of Faulty Posture," by Dr. Lloyd T. Brown, which appeared in the January issue.

SINCE "unnatural posture causes fatigue, reduces vitality, tends to deformity and always results in reduced production and earning power," the question of proper work chairs for those engaged in sedentary pursuits is of great importance. How to prevent the disastrous effects of poor poor posture are described in a brief article in *The Journal of Industrial Hygiene*, prepared by Dr. Joel E. Goldthwait, orthopedic surgeon, and Dr. Arthur B. Emmons, 2nd, Director of Harvard Mercantile Health Work.

In the past, say the authors, chairs were evidently designed for resting, not working. The common bent wood chair supports only the shoulders when one leans back. Yet at work the small of the back bulges directly backward, and needs support. A work chair developed according to the findings of a committee of which Dr. Goldthwait was the chairman, and Dr. Lloyd T. Brown a member, offers relief to sedentary workers, many of whom spend one-half of their waking hours in a chair. The manufacturers of this chair quote from another article by Dr. Goldthwait published in *Health*, the effect of posture upon health. With the body erect the head is held up and the blood flows to and from the brain easily. This conduces to alertness and quick reactions. The chest is held up, proper breathing is carried on easily, and the digestive and other organs function properly.

The chair, which is of rigid construction, has as its most important features an *inward curvature of the back* and a *shallow seat*. It has been found a great improvement over the ordinary chair, although Dr. Emmons has recently expressed a preference for a chair developed from the original work chair, but made on the same principle. This chair (which we reproduce), made by P. Derby & Company, Gardner, Mass., he believes is "the most satisfactory type of simple, substantial, inexpensive chair, generally useful, well adapted to office work even by 'billers' who must repeatedly turn from the files to the typewriter."

*A Good Postural Chair*

"Executives' chairs are usually the worst from a postural standpoint," says Dr. Emmons. "In introducing a good postural chair one invariably meets the human reaction against any change—any unaccustomed thing. The reaction is 'strangeness" often interpreted as unfavorable. It may take a week to overcome this. Therefore ask for at least two weeks' trial before passing judgment. A year later you could not induce anyone to go back to the old chair."

A valuable bibliography on seating is contained in *Special Bulletin 104,* prepared by the Bureau of Women in Industry, and published by the Industrial Commission of the Department of Labor of the State of New York. This bulletin is unfortunately out of print but may be consulted with other valuable material at the New York office of the Bureau, 124 East 28th Street, New York City. The bulletin, which presents a study of bad posture in industry, to which it refers as a preventable cause of fatigue, makes the following conclusions:

*Posture must be varied.* Rest and an enormous saving of energy result from a change of position during working hours. Continuous standing and sitting are both injurious. The effects of a constrained position combined with a sedentary life are very injurious. Clerical workers are more efficient if they get up, walk around and stretch at intervals.

*Work conditions should be such that correct posture is possible.*

Posture is affected by innumerable working conditions, lighting, speed of operation, the clothes the worker wears, and the ordinary factory seat.

Commenting on the boast of one firm that it makes "a seat that never wears out," the bulletin suggests that a better slogan would be "The seat that wears the worker out."

In *Fatigue Study,* Macmillan Co., a volume of 169 pages, written by Frank M. and Lillian M. Gilbreth, the writers suggest that every working girl should be measured for her working chair. It is important, they feel, that the height of the worker's elbows bear the same relation to her work place when she is sitting as they would if the work place were properly adjusted for her to do standing work. In young workers especially it is surprising how quickly proper devices will induce the correct posture.

Nine types of work chairs designed for different industries and with different end results in view are exhibited in the National Fatigue Museum, part of the Medical Museum of the Surgeon General's department at Washington. The authors feel that it would be a good thing if every factory as well as every college were to establish a fatigue museum.

The American Posture League, 30 Church Street, New York City, will furnish information and literature on posture.

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## MAY DAY

Plans for May Day, National Child Health Day, have been perfected, and few residents of these United States can be ignorant of its significance in the movement for child health. For under the leadership of the American Child Health Association, magazines have promised May Day covers, editorials and child health articles, newspapers will give space to news and feature articles, and leading advertisers will focus their advertising on National Child Health Day.

The General Federation of Women's Clubs is working with the State Departments of Health and Education, the National Congress of Parents and Teachers is coöperating and the Extension Service of the U. S. Department of Agriculture has pledged its interest. May Day chairmen have been appointed in each state.

In the Booknotes of this issue we are calling attention to the May Day Festival Book, published by the American Child Health Association.

# ACTIVITIES OF THE N.O.P.H.N.

*Edited by* ANNE A. STEVENS

## SALARIES OF PUBLIC HEALTH NURSES *

### *Salary Policies in Non-official Public Health Nursing Organizations*

Although the questionnaire asked for information regarding salary policies, that is, the beginning and maximum monthly salary, the increases of monthly salary and period of service before receiving increases, of all full-time graduate nurses employed—directors, assistant directors, supervisors and staff nurses—very little information is given for any but salaries of staff nurses.

This fact would seem to indicate that non-official organizations employing public health nurses have no definite and expressed salary policy except in regard to staff nurses. Salaries of directors, assistant directors and sometimes supervisors are apparently decided in relation to the individual and not in accordance with a minimum and maximum for the position.

Table 2 shows the policy regarding the salaries of staff nurses: the beginning monthly salary, the maximum monthly salary, and length of service before maximum salary is received. These are classified only by population group. It is interesting to compare Table 2 with Table 1 and note how many staff nurses in each population group are receiving the beginning or maximum monthly salaries and how many some salary between these extremes. A comparison of the salary policies in the different population groups is also interesting.

The number of months of service before reaching the maximum salary varies from six months to five years.

It has not been possible to put in tabular form the number of increases before reaching the maximum monthly salary, or the period of services between increases. However, some statements can be made regarding these points. Of the 59 organizations which report both a beginning and a maximum monthly salary, 2 give increases on merit; 7 have definite increases in monthly salary for definite length of service for two or more increases, but the maximum monthly salary is given on merit or for some special reason. One organization reports a course in public health nursing must be taken before the maximum salary is given. The remaining 50 have definite increases in the monthly salary after definite intervals of service.

The amount of the monthly increase and length of service before receiving increases varies. The most common monthly increase is $5. Ten dollars and $15 are also given and some few organizations give $8.33 increase.

Of the organizations giving information as to length of period before giving first increase in monthly salary, 27 give it at end of 3 months' service, 16 at end of 6 months' service, 14 at end of 1 year's service, 7 at end of 2 months' service, and 1 at end of 1 month's service.

Following are the salary policies of three organizations:

Organization A: $8.33 a month increase at the end of two months, six months, and one year of service, when maximum salary is received.

Organization B: $10 a month increase at end of three months; $5 a month increase at end of one year; and $5 a month increase at end of three years, when maximum salary is received.

Organization C: $8.33 a month increase at end of three months, one year and two years; $5 a month increase at end of three years and four years, when maximum salary is received.

### *Salaries of Official Public Health Nursing Organizations*

As fewer questionnaires were received from official public health nurs-

* Continued from February magazine.

*TABLE 2. POLICIES REGARDING SALARIES OF STAFF NURSES OF SELECTED NON-OFFICIAL PUBLIC HEALTH NURSING ORGANIZATIONS CLASSIFIED BY POPULATION GROUP
1924

| Cities of 700,000 or more | | | Cities of 200,000 to 700,000 | | | Cities of 100,000 to 200,000 | | | Cities of 50,000 to 100,000 | | | Cities of 25,000 to 50,000 | | | Cities of less than 25,000 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Beginning monthly salary | Maximum salary | | Beginning monthly salary | Maximum salary | | Beginning monthly salary | Maximum salary | | Beginning monthly salary | Maximum salary | | Beginning monthly salary | Maximum salary | | Beginning monthly salary | Maximum salary | |
| | Amount per month | When reached | | Amount per month | When reached | | Amount per month | When reached | | Amount per month | When reached | | Amount per month | When reached | | Amount per month | When reached |
| (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) | (12) | (13) | (14) | (15) | (16) | (17) | (18) |
| $100.00 | X | X | $90.00 | $120.00 | Indefinite | $85.00 | $110.00 | 2 yrs. | $90.00 | $130.00 | 3 yrs. | $100.00 | X | X | $100.00 | $135.00 | 4 yrs. |
| 105.00 | $120.00 | 1 yr. | 100.00 | X | X | 90.00 | 125.00 | 1 yr. | 100.00 | Not established | Not established | 100.00 | $110.00 | 1 yr. | 100.00 | 140.00 | X |
| 110.00 | 130.00 | 3 yrs. | 100.00 | 125.00 | 2 yrs. | 95.00 | 110.00 | 1 yr. | 100.00 | 115.00 | 1 yr. | 100.00 | 125.00 | 3 yrs. | 110.00 | 125.00 | 1 yr. |
| 110.00 | 140.00 | 5 yrs. | 100.00 | 125.00 | 2 yrs. | 95.00 | 125.00 | 1 yr. | 100.00 | 115.00 | 1 yr. | 104.17 | 133.33 | 4 yrs. | 125.00 | 150.00 | 4 yrs. |
| 115.00 | X | X | 100.00 | 125.00 | 2 yrs. | 100.00 | X | X | 100.00 | 125.00 | X | 110.00 | 145.00 | 3 yrs. | 125.00 | 150.00 | 3 yrs. |
| 116.67 | 141.67 | 1 yr. | 100.00 | 125.00 | 3 yrs. | 100.00 | 110.00 | 2 yrs. | 100.00 | 125.00 | 2 yrs. | 110.00 | 150.00 | 5 yrs. | 135.00 | Not established | Not established |
| 116.67 | 141.67 | 1 yr. | 105.00 | 115.00 | 1 yr. | 100.00 | 115.00 | 6 mos. | 105.00 | X | X | 115.00 | 125.00 | 1 yr. | .... | .... | .... |
| 120.00 | 140.00 | 2 yrs. | 110.00 | 125.00 | 4 yrs. | 100.00 | 120.00 | When voted | 110.00 | 125.00 | 6 mos. | 115.00 | 130.00 | 5 yrs. | .... | .... | .... |
| 125.00 | 145.00 | 21 mos. | 115.00 | 130.00 | 2 yrs. | 100.00 | 120.00 | 1 yr. | 110.00 | 130.00 | 6 mos. | 115.00 | 135.00 | 3 yrs. | .... | .... | .... |
| 125.00 | 150.00 | 1 yr. | 120.00 | 140.00 | 3 yrs. | 100.00 | 120.00 | 1 yr. | 110.00 | 130.00 | 2 yrs. | 125.00 | X | X | .... | .... | .... |
| 125.00 | 150.00 | Indefinite | .... | .... | .... | 100.00 | 120.00 | 2 yrs. | 125.00 | X | X | 125.00 | 125.00 | .... | .... | .... | .... |
| 130.00 | 150.00 | 2 yrs. | .... | .... | .... | 100.00 | 125.00 | 1 yr. | 125.00 | 150.00 | 2 yrs. | 125.00 | 130.00 | 5 yrs. | .... | .... | .... |
| X | 141.67 | Indefinite | .... | .... | .... | 100.00 | 135.00 | X | .... | .... | .... | .... | .... | .... | .... | .... | .... |
| .... | .... | .... | .... | .... | .... | 100.00 | 150.00 | Indefinite | .... | .... | .... | .... | .... | .... | .... | .... | .... |
| .... | .... | .... | .... | .... | .... | 110.00 | 125.00 | 3 yrs. | .... | .... | .... | .... | .... | .... | .... | .... | .... |
| .... | .... | .... | .... | .... | .... | 110.00 | 135.00 | 1 yr. | .... | .... | .... | .... | .... | .... | .... | .... | .... |
| .... | .... | .... | .... | .... | .... | 110.00 | 135.00 | 3 yrs. | .... | .... | .... | .... | .... | .... | .... | .... | .... |
| 12 | 11 | 11 | 10 | 9 | 9 | 17 | 16 | 15 | 12 | 10 | 9 | 12 | 10 | 10 | 6 | 6 | 5 |

X No information.
* Table 1. Published in February magazine, pages 98 to 101.

TABLE 3. SALARIES PAID BY SELECTED OFFICIAL PUBLIC HEALTH NURSING ORGANIZATIONS CLASSIFIED BY POPULATION GROUP
November 30, 1924
Salaries tabulated to nearest $5.00

1. SALARIES PAID DIRECTORS

| Monthly salary (1) | Number receiving specified salary in cities of— 700,000 or more (2) | 200,000 to 700,000 (3) | 100,000 to 200,000 (4) | 50,000 to 100,000 (5) | 25,000 to 50,000 (6) | Less than 25,000 (7) |
|---|---|---|---|---|---|---|
| Total | 4 | 2 | 1 | 3 | 1 | — |
| $250.00 | .... | .... | .... | 1‡ | .... | .... |
| 235.00 | 1** | .... | .... | .... | .... | .... |
| 230.00 | 1† | .... | .... | .... | .... | .... |
| 225.00 | 1‡ | .... | .... | .... | .... | .... |
| 210.00 | 1† | .... | .... | .... | .... | .... |
| 200.00 | .... | 2* | .... | .... | 1** | .... |
| 175.00 | .... | .... | .... | 1* | .... | .... |
| 170.00 | .... | .... | 1‡ | .... | .... | .... |
| 150.00 | .... | .... | .... | .... | .... | .... |
| 140.00 | .... | .... | .... | .... | .... | .... |
| 125.00 | .... | .... | .... | 1** | .... | .... |

† In organizations with 50 or more nurses. * In organizations with 10 to 24 nurses.
‡ In organizations with 25 to 49 nurses. ** In organizations with 2 to 9 nurses.

2. SALARIES PAID SPECIAL SUPERVISORS

| | | | | | | |
|---|---|---|---|---|---|---|
| Total | 8 | 6 | 1 | 1 | — | — |
| $200.00 | 1† | .... | .... | .... | .... | .... |
| 175.00 | 4† | 1* | .... | .... | .... | .... |
| 170.00 | .... | .... | .... | .... | .... | .... |
| 165.00 | 2‡ | .... | .... | .... | .... | .... |
| 160.00 | .... | 1* | .... | .... | .... | .... |
| 155.00 | 1† | 1‡ | .... | .... | .... | .... |
| 150.00 | .... | 3§ | 1* | 1** | .... | .... |

†In organizations with 50 or more nurses.
‡In organizations with 25 to 49 nurses.
* In organizations with 10 to 24 nurses.
**In organizations with 2 to 9 nurses.
§ {2 in organizations with 50 or more nurses.
{1 in organizations with 10 to 24 nurses.

3. SALARIES PAID DISTRICT SUPERVISORS

| | | | | | | |
|---|---|---|---|---|---|---|
| Total | 60 | 14 | 1 | 1 | — | — |
| $160.00 | 14† | .... | .... | .... | .... | .... |
| 155.00 | .... | .... | .... | .... | .... | .... |
| 150.00 | .... | 1† | 1* | .... | .... | .... |
| 145.00 | 44§ | 1† | .... | .... | .... | .... |
| 140.00 | 2‡ | 9§§ | .... | .... | .... | .... |
| 135.00 | .... | 1† | .... | 1** | .... | .... |
| 130.00 | .... | .... | .... | .... | .... | .... |
| 125.00 | .... | .... | .... | .... | .... | .... |
| 120.00 | .... | .... | .... | .... | .... | .... |
| 115.00 | .... | 2* | .... | .... | .... | .... |

† In organizations with 50 or more nurses.
‡ In organizations with 25 to 49 nurses.
* In organizations with 10 to 24 nurses.
** In organizations with 2 to 9 nurses.
§ {41 in organizations with 50 or more nurses.
{3 in organizations with 25 to 49 nurses.
§§ {4 in organizations with 50 or more nurses.
{5 in organizations with 25 to 49 nurses.

4. SALARIES PAID STAFF NURSES

| | | | | | | |
|---|---|---|---|---|---|---|
| Total | 253 | 91 | 38 | 65 | 6 | 3 |
| $160.00 | 31 | .... | .... | .... | .... | .... |
| 155.00 | 7 | .... | .... | .... | .... | .... |
| 150.00 | 7 | .... | 3 | 20 | .... | .... |
| 145.00 | 13 | .... | .... | .... | .... | .... |
| 140.00 | 47 | 28 | .... | 2 | .... | 1 |
| 135.00 | 23 | 1 | 2 | .... | .... | 2 |
| 130.00 | 72 | 10 | .... | .... | .... | .... |
| 125.00 | .... | 7 | 6 | 9 | .... | .... |
| 120.00 | .... | 26 | .... | .... | .... | .... |
| 115.00 | .... | 17 | .... | .... | 6 | .... |
| 110.00 | 53 | 1 | 14 | 15 | .... | .... |
| 100.00 | .... | .... | 10** | 5 | .... | .... |
| 95.00 | .... | .... | .... | .... | .... | .... |
| 90.00 | .... | .... | 2* | 7† | .... | .... |
| 85.00 | .... | 1 | .... | 7* | .... | .... |
| 65.00 | .... | .... | 1* | .... | .... | .... |

* Colored nurses. ** One colored nurse. † Four colored nurses.

ing organizations it was not practical to make Table 3 the same as Table 1. The organizations are classified only by population group and not by number of graduate nurses employed. In divisions 1, 2, and 3 the size of organizations with which the nurses are connected is indicated by footnotes.

So few organizations, reporting, had assistant directors, this division of Table 1 is omitted in Table 3. Salaries reported for 3 assistant directors are $185, $150, and $135 a month.

How salaries paid by official public health nursing organizations compare with those paid by non-official organizations can be determined from a study of Table 1 and Table 3.

Table 4 gives information about the policy regarding the salaries of staff nurses of official public health organizations and is similar to Table 2. In comparing these two tables, we find that one official public health organization has a higher maximum salary than any non-official public health organization, and one official organization a lower maximum salary than any non-official public health organization.

Little information is given regarding the salary policies of official public health nursing organizations. The plans of those given are much the same as for non-official organizations.

*Salary Policy for 1925*

Of the 106 public health nursing organizations, both official and non-official, which returned questionnaires, only 19 organizations report any change in 1925 in salaries. One organization is revising the salaries paid to all nurses employed. Ten other organizations are making changes in the salaries of staff nurses; 7 of these are increasing their maximum monthly salary, and their policy regarding increases; 2 are increasing the maximum monthly salary, and one is changing the number and amount of monthly increases. Five organizations, other than the one making changes in all salaries, are increasing the salaries paid directors, one salary being very low. Four organizations, other than the one changing all salaries, plan to raise salaries paid supervisors.

This statement regarding the salaries paid by both official and non-official public health nursing organizations does not attempt to be a discussion of the information obtained but merely to show how these tables can be used and how those interested can study the salaries of public health nurses.

L. M. T.

TABLE 4. POLICY REGARDING SALARIES OF STAFF NURSES IN OFFICIAL PUBLIC HEALTH NURSING ORGANIZATIONS, CLASSIFIED BY POPULATION GROUP
1924

| Cities of 700,000 or more | | | Cities of 200,000 to 700,000 | | | Cities of 100,000 to 200,000 | | | Cities of 50,000 to 100,000 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Beginning monthly salary | Maximum salary | | Beginning monthly salary | Maximum salary | | Beginning monthly salary | Maximum salary | | Beginning monthly salary | Maximum salary | |
| | Amount per month | When reached | | Amount per month | When reached | | Amount per month | When reached | | Amount per month | When reached |
| (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) | (12) |
| $110.00 | $130.00 | 2 yrs. | $105.00 | $130.00 | Indefinite | $100.00 | $125.00 | 3 yrs. | $83.33 | $100.00 | 3 yrs. |
| 116.66 | 133.33 | X | 110.00 | 135.00 | 2 yrs. | 110.00 | 135.00 | 1 yr. | 100.00 | 125.00 | 10 mos. |
| 130.00 | 158.00 | 5 yrs. | 110.00 | Not established | X | 150.00 | X | X | 125.00 | 125.00 | .... |
| | | | 120.00 | 140.00 | 2 yrs. | | | | 140.00 | 150.00 | 1 yr. |
| 3 | 3 | 2 | 4 | 4 | 3 | 3 | 2 | 2 | 4 | 4 | 4 |

X No information.
Note: Organizations located in places of less than 50,000 population give no information regarding salary policies.

# POLICIES AND PROBLEMS OF PUBLIC HEALTH NURSING SERVICES

## VISITING NURSE STUDY REPORT

AS REPORTED previously in THE PUBLIC HEALTH NURSE, a committee has been appointed by the National Organization for Public Health Nursing to consider all questions raised in the attempts to put into operation the recommendations of the Report of the Committee to Study Visiting Nursing. This Committee has had one meeting, at which many questions were considered and answers drafted. Additional questions and answers will be published from time to time.

### *Questions and Answers Considered by Committee*

*Dismissed Cases and Adult Welfare Visits*

**Question 1.**

"The nurse has discharged a patient and a week or so later will be called in to see another patient in the immediate neighborhood. Some neighbor or relative of the discharged patient sees the nurse and asks her to come in to see how the discharged patient is. The nurse's time is consumed. Where shall this visit be listed?"

Answer:

It was decided by the Committee that this class of visits should be put under a new heading, "Visits to Patients Not Taken Up."

**Question 2.**

"The nurse visits a sick patient and when leaving the home is called in by a neighbor. The neighbor is not necessarily ill, but she may be complaining and wants advice as to her condition. Where shall this visit be listed?"

Answer:

It was decided that these visits should be included under a new heading, "Visits to Patients Not Taken Up."

**Question 3.**

"A visit is made to an orthopedic case to ascertain if patient is wearing her brace. Should these visits be listed under Chronic or Welfare?"

Answer:

The Committee decided that these visits should be listed under the heading "Surgical."

**Question 4.**

How shall we record follow-up work in which the health of the whole family is the purpose of the visit?

Answer:

It was decided that any agency carrying on a type of work not included on the time and visit record might add a column for recording these visits. A careful definition of this heading should be given.

**Question 5.**

How shall we record Mental Hygiene visits?

Answer:

It was decided that a column should be added for Mental Hygiene visits under visits to patients.

**Question 6.**

How will visits to well employees be listed? For example an Association writes: "We have a contract with an industrial firm by which a nurse visits the home of each of the employees once every two months to ascertain the general home conditions and to act as a friendly health visitor. How should these home visits be classified unless we have a column for Adult Welfare?"

Answer:

It was decided that, since under the Welfare Classification, infant, child, and school were listed, "Adult" should be added. This would make a very definite place for recording this and many other similar visits.

*Maternity Service*

**Question 7.**

"If a maternity case is visited several hours previous to delivery, but nurse does not stay for delivery, where will this visit be listed?"

Answer:

It was decided that this should be classified as a prenatal visit.

**Question 8.**

"In recording your delivery service and approximating the number of visits equivalent for a delivery that has taken three hours (our average length of visit being 45 minutes) do you count this as

two post-partum and two new-born or do you record it as one delivery equivalent to four nursing visits?"

Answer:

It was decided that they should record it as one delivery equivalent to four nursing visits.

*Office Visits Made by Nurse*

**Question 9.**

"Are visits made to M.L.I. office or to Board of Health to be listed under 'visits on behalf of patients' or under 'assigned duties'?"

Answer:

The Committee decided that these visits should be included under "visits on behalf of patients."

*Visits to Office Made by Patients*

**Question 10.**

"If patient is asked to call at nurse's office for dressings or for other treatments, by doctor's permission, where should these visits be listed?"

Answer:

It was decided that these should be classified as visits to patients, going under the medical or surgical columns, etc., according to the kind of visit.

**Question 11.**

"Where should visits to Child Welfare Stations be listed if a physician is in charge? Under 'group meetings' with patients or under 'special activities'?

Example: Formerly, before the establishment of these stations, we visited the babies once a month up to two years of age. Since the stations have been established, we carry the babies until they are one calendar month old and then dismiss them to the Child Health Stations. We have a physician in the station but we do not dispense milk. Therefore, as this saves home visits, I am puzzled as to whether these should be included under Special Activities or under Group Meetings with Patients."

Answer:

It was decided that this should go under the heading "Special Activities."

*What Are We to Regard as Chronic Cases?*

**Question 12.**

"If visits run over a long period of time even though diagnosis indicates an acute stage, should these be listed as chronic cases?"

Answer:

The Committee decided that the first diagnosis was the one under which visits should be listed, regardless of time carried if acute conditions persisted. It was decided that visits to patients carried over a long period of time which do not include care of an acute condition, special treatments or dressings, but are made mainly for the general physical care and comfort of the patient, shall be listed under chronic.

**Question 13.**

"When are medical supplies to be considered as relief, and when to be included in the cost per visit?"

Answer:

The Committee decided that all supplies which were essential for the nursing care of the case are to be included in the cost of the visit, but such additional things as medicine, medical appliances like crutches or braces, are to be considered as medical relief. (See pp. 115 and 116 of the report.)

**Question 14.**

"On what basis will the organization determine how many staff nurses would be needed to replace student nurses?"

Answer:

The Committee decided that this would be determined on the basis of the number of visits the student nurse makes as compared with the number of visits a staff nurse makes.

**Question 15.**

"On what basis will the two-thirds of the salary of the staff nurses necessary to replace students be determined?"

Answer:

The Committee decided that it would be based on the minimum staff nurse salary.

**Question 16.**

Shall staff conferences consisting of talks, demonstrations, or explanations of new public health measures be listed under "Assigned Duties of Indirect Value"?

Example: In an organization such as ours, with no student nurses and where we average two new nurses a year, would not our staff conferences come under "Staff Education" rather than "Assigned Duties of Indirect Value to Patients"? The staff conferences consist of talks and demonstrations or explanations of new public health measures, etc., and hence I suppose should not be called staff conferences. We have no regular formal classes. Once a month we have an outside speaker. This is our only attempt at continuous staff education.

Answer:

It was decided that these staff conferences were to be listed under "Assigned Duties of Indirect Value."

**Question 17.**

Should visits by staff to clinics or dispensaries for observation be listed under "Assigned Duties of Indirect Value"?

Example: Each nurse on the staff is sent to observe at the various clinics, etc., in the city as part of their "education," *i.e.*, each nurse once during her stay on the staff spends a morning at the prenatal clinic, one at the dispensary, one at the venereal disease clinic, etc. We have always included this under "Education." Should it come under "Assigned Duties of Indirect Value"?

Answer:

It was decided by the Committee that visits by staff nurses should be listed under "Assigned Duties of Indirect Value," but visits by student nurses should not.

Another point which came up was the question of "patients" in the column, "Other Services in Behalf of Patients" on Form 1. It was decided by the Committee that the heading "patients" under "Other Services in Behalf of Patients" should be excluded, and only the hours spent in this work should be recorded.

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## A PUBLIC HEALTH FORUM

Under "A Public Health Forum," printed on page 656 of the December issue, there appeared the following Question and Answer:

*Question:* What nursing work is the legitimate function of a Health Department?

*Answer:* "Only such nursing work should be provided by a Health Department as can be offered to the members of the community needing the service, regardless of income." The Health Department Nursing Work thus expresses itself in terms of a strictly "educational" preventive and police service. *Explanation*—Accepting this statement a Health Department as such is not justified in providing a nursing service for the care of the sick (unless this service is provided free to all, which it is generally agreed is an unsound policy). Nor is it justified in providing clinic service for treatment of any sort not open to all.

Miss Mabelle S. Welsh, of the East Harlem Nursing and Health Demonstration, New York City, makes the following comment:

It seems to me that any Health Department is quite right to keep out of the field of bedside nursing. On the other hand, I think that the care of the sick in their homes might logically be subsidized by any city government, just as private hospitals receive grants for the care of the sick poor. When one considers the great amount of illness in the homes that is cared for by the private agencies and the large proportion of their budgets which must go for free service, one wonders how long philanthropic individuals will meet this great expense, and why it should not be a responsibility of all taxpayers.

As time goes on, the municipalities should assume more and more of this responsibility, until eventually public health nursing is publicly supported, as are the public schools, libraries, museums, etc. It would seem highly desirable to have all well organized nursing services brought together under a common community administration. In older communities this will be difficult to bring about, because of the personality which institutions, like individuals, assume. But just as the New York Public Library represents an amalgamation of famous private libraries, may we not visualize a future when a municipal nursing service will be an amalgamation of similarly famous private organizations, the supporters of which carry over into a community program increased enthusiasm and wholehearted interest.

It will be possible to realize such a program when by public education the people of a great community are taught to realize that the conservation of health is at least as important as the preservation of material property.

## VALUE AND FUNCTIONS OF A NURSING COMMITTEE

*Discussions of this question were printed in the March issue.*

The *value and function of a nursing committee* cannot be overestimated if any community wishes to have its public health program a success. The character of work and organization of this committee must depend upon the scope and type of program to be promoted by the committee. For example: (a) one county nurse versus several in a county; (b) some employed by school boards, some by township boards, some by private organizations.

The value of a committee depends, to a great extent, upon a strong county representation. Besides the chairman, there should be representation from agencies functioning on a county-wide basis in educational, health or social work; a strong newspaper representation; official representation such as the chairman of the Board of Supervisors; and lay members interested not only in public health, but in county problems.

Our interpretation of the functions of a nursing committee is: First, to make a study of health conditions in the county and to secure the interest of representative groups, volunteer givers or governmental agencies, whoever must carry on the work financially in promoting a public health program. Second, to employ a nurse and to make known to the public that the nurse employed meets the requirements set down by the national public health organization for public health nursing. Third, to hold regular meetings with the nurse, hear her report for the past month and her plans for the ensuing month, and make constructive criticism from the standpoint of the community. Fourth, to understand through the nurse something of her point of view and what she is trying to do in the community, and in turn, to help the nurse to understand the community and to know how to approach and how best to establish her work so that it will continue a permanent community activity. Fifth, assist in organizing a local organization of representative people to assist in the community health program, should a village or township decide to make an appropriation for intensive service in that community. Sixth, to see that the community sponsors and assists with clinics established under the supervision of the Committee on Nursing Activities.

*Committee on Nursing Activities, American Red Cross, Detroit Chapter, Wayne County, Michigan.*

***We have recently received a letter from one of our members from which we abstract these interesting paragraphs. We know that this is not an unusual situation. Will some of our readers who have solved this problem for themselves give us the benefit of their experience?***

The discussion of the "Value and Functions of a Nursing Committee" has been valuable indeed, and has brought much light on proper functioning of the same. But—what I would like to know is how I am going to get the committee to meet regularly? How shall I proceed to organize a committee that *will* function? I have tried out every theory that I have heard about and still my committee does not meet regularly, and the sub-committee hardly believes that it exists. We are too far from other health centers for our committee to observe the work of other committees.

I know my case is not an exception in these counties, just being organized, and I am speaking for them as well as myself.

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## SUNDAY WORK

*A discussion of this question appeared in the January issue.*

During 1924 we had an average of 70 nurses, and 52 of these were available for Sunday duty. The assignments are made from a card catalogue. The first of each month assignments are made for the four or five Sundays in that month, two nurses to serve

each Sunday. The average for the year discloses the fact that 52 nurses served twice for Sunday duty. The routine for Sunday duty is as follows:

All substations are closed as well as the central office. The Nurses' Central Directory is in the same building with the Visiting Nurse Association, is open 24 hours, and takes our calls from 5:00 P.M. to 8:00 A.M. and all day Sunday and afternoons of holidays. Anyone wishing to refer an old case for Sunday duty is requested to put the call in by 5:00 P.M. Saturday. When the Registrar leaves at 5 o'clock she has the Sunday duty calls arranged.

It is the responsibility of the first nurse to come to the central office at 8:30 A.M. and take whatever new calls may have come in through the Directory; with these and the old calls she makes her day's schedule, dividing the work with the second nurse, to whom she telephones her portion. On Monday morning the two Sunday duty nurses come to the central office with their reports and this information is then passed on by the Registrar to the supervisors in whose districts the patients have received Sunday care.

Sunday time is not made up during the week unless the nurse works more than half a day. We have carefully tried to reduce the amount of Sunday work. We have carried on Sunday a total of 363 visits, which is an average of 6 visits per Sunday. The nurse decides whether or not the patient needs a Sunday call and the decision is based strictly on the need, not on the patient's ability to pay. We are frequently asked to care for patients who could pay us hourly rates for Sunday duty, but we refer this work to the Nurses' Directory, which has a number of nurses who do hourly work at $2.00 per hour. Naturally, we give Sunday care when there is no one in the home to give it, and in instances of acute illness or untoward symptoms which indicate the need of a skilled person's service.

*Holiday Service:* The substations and central office are open until noon on all holidays, excepting Thanksgiving and Christmas, when the Sunday routine is followed.

*Visiting Nurse Delivery Service:* It is only fair in connection with Sunday work to explain our delivery or confinement service.

We have seven nurses and a supervisor. The supervisor follows the regular schedule time of 8:30 A.M. to 5:00 P.M. The three day nurses are assigned to respective substations and do district work between delivery cases. The three night nurses are on call from 5:00 P.M. to 7:00 A.M., and whether they work or not, they are free during the day. Each day nurse has a day off, and each night nurse has a night off, and the seventh nurse furnishes their relief, which means of course that she works three days and three nights of each week and has Sunday off.

Nurses are rotated from the general staff to this service in chronological order. It is expected that each nurse will be assigned two months out of twelve to this service, one month of day duty and one month of night duty. Therefore while the 52 nurses who had only two Sundays of general field duty had during the year eight Sundays of Delivery Service, in the aggregate this makes ten Sundays out of the year on duty. During December, 1924, the seven nurses assisted with 100 deliveries, averaging four hours plus per case, and the three assigned to day duty cared for 239 additional patients. It is easily seen that seven nurses to 100 labors is an average of 14 per nurse, which plainly indicates that while the nurses are on call they are not always at work. Hence we feel that our Sunday duty is at a minimum.

*Visiting Nurse Association, Detroit, Michigan.*

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*The discussion of Transportation will be continued in the May issue.*

# RED CROSS PUBLIC HEALTH NURSING

EDITED BY ELIZABETH G. FOX

## WHAT IT MEANS TO BE A NURSING FIELD REPRESENTATIVE OF THE AMERICAN RED CROSS

ONE of the delightful perquisites attached to the service of a nursing field representative of the American Red Cross is the opportunity it so frequently affords each one of us of meeting at the most unexpected times and in the most unheard-of places, old friends—professional and otherwise—who, after the first gasp of astonishment is over, very naturally ask, "Well, what are you doing here?" When you have reached the end of your very high-sounding title, she still looks mystified and says, "Well, begin at the beginning and tell me all about it." And, beginning at the beginning, this is somewhat the story we usually tell.

The working unit of the American Red Cross is the chapter which usually covers a county. One of the main links between these chapters, of which there are over three thousand, and the National and Branch Offices, is the field staff, numbering about one hundred, of whom about one-third are nurses. To interpret to the chapters the program and policies of the National Organization, to bring to them the suggestions and advice of the National administrative and service directors and to aid them to solve their difficulties is one side of the field staff's responsibility, while on the other is that of keeping the National Organization in touch with the needs and wishes of the chapters.

When a new nursing field representative is appointed, she is asked to report to the National or Branch Office and to spend several weeks there in preparation for her work in the field, for not only must she master the technique of her own service, but must thoroughly understand the program and policies of the American Red Cross as a whole, and the relation the nursing service bears to the other activities of the organization. Here she meets the various service heads and learns about the aims and methods of the services they direct; becomes acquainted with her co-workers in the field; reads the histories of the chapters she will visit, making notes and summaries for future reference; and finally arrives at the time when she drafts her first itinerary, which must be economical in three things—time, money and strength. Headquarters sends out notices to the chapters of her coming, and at the appointed time she fares forth with the same old "gone" feeling in the pit of her stomach she first met with when she stood at the entrance of her first patient's room and tremblingly pictured and wondered what she was going to find on the other side of that door, once she gained courage to open it.

On arrival at the county seat or wherever the chapter headquarters are located, the representative gets in touch with the office and finds out what plans have been made for her visit, and sets about her work of assisting in every possible way in the development and success of the nursing service and in the coördination of this service with other chapter activities. During her visit to the chapter the representative always expects to see the chairman of the chapter and the chairman of the nursing committee, the nursing staff, as well as all persons, committees or organizations they may wish her to meet.

The representative goes over with the nurse in person her monthly reports, her case histories, social histories, school and clinic records, her daily sheet, her bag and equipment in the same way as does a supervisor in any well organized visiting nurse asso-

ciation. This gives a certain insight into the work and general ability of the nurse and many opportunities for helping her with suggestions. But the best results come when the representative climbs with the nurse into her faithful Ford, and banging the door finally and successfully shut, starts off with her over the hills, out into the country, into the schools, the homes and the clinics. Then comes the opportunity for a heart-to-heart talk with her, resulting in much keener insight into her real problems. As the two roll along they talk over the contacts that are difficult, the family problem that is hard to solve, and the representative aims to give the nurse something fresh from the outside, perhaps a better means of approach to certain people or situations, and most of all, some spark, at least, of inspiration to fan the flame which from overstress of work is likely at times to burn a bit dimly.

Fortunately for all persons concerned, the nursing service is of a nature to dovetail very well with all the activities of the Red Cross program. One finds the home service worker and nurse working hand-in-hand on a soldier's case, for there is scarcely one of the home service worker's cases of ex-service men or their families in which there is not a health program. Junior Red Cross makes a strong appeal to the nurse, and she is frequently the first person to interest the teacher and the pupils in this program. Certain it is, that she never makes a health talk in any school without some reference to the Junior Red Cross Calendar. Many of the home hygiene classes are taught by the public health nurses and they are doing much to promote nutrition activities, life saving programs, and all the other enterprises of the Red Cross.

A leaf from the log of a field representative may give the reader an idea of just how the days speed by:

Jan. 22—Friday. Arrived at Blankville 11 A.M. Train 3 hours late on account of snow. Registered at hotel. Went to chapter office. Nurses just in from their rounds. Message from chapter chairman that she would call for representative at noon, and wanted the latter to attend Conference luncheon at Womans Club with her. Spoke briefly on Red Cross Public Health Nursing Service and coöperation with other agencies. Returned to office at 3 P.M. and went over certain details of their work with the nurses. Back to hotel at 5 P.M. Mailed special report off to Washington at 10 P.M. Sat. 23. Rounds with nurses all morning. 2 P.M. meeting nursing committee; three important subjects for discussion: (1) Enlargement service; (2) development special demonstration in maternal and child care jointly with state through Sheppard-Towner Fund; (3) creation medical advisory committee from County Medical Society. After discussion, voted to recommend to Executive Committee that all three be undertaken. 3:30 P.M. Meeting Executive Committee. After routine business finished, recommendations from nursing committee confirmed and committee instructed to proceed with plans. 5 P.M. to hotel. Evening spent in playing bridge at chapter chairman's home with old college friends. To bed at midnight, gratefully remembering next day was Sunday, since the week's program had been in the same key as two days described. Representative hung out, "Do not disturb," and lay down to pleasant dreams.

On Monday she would be at work again in another chapter. The number of visits to each chapter and the length of the visit are determined by the need. There is no set rule.

Chapter visits are by no means the only responsibility of the representatives. There are innumerable contacts to be made. The fall months are usually busy starting off with the Red Cross National Convention in October, then a series of regional conferences through the states. The nursing and general field representatives work together to make these conferences a success, and there is much friendly rivalry between the various members of the field staffs as to which can put over the best conferences and secure the largest attendance. In the spring months, nursing representatives usually arrange a one-day conference in their territory devoted entirely to the consideration of public health nursing questions, from the standpoint both of the committee and nurse.

There are also the meetings of the various state organizations, Social Workers' Conference, State Tuberculosis Society, State Nurses' Associa-

tion, State Organization for Public Health Nursing and others. In some states there are conferences on school nursing under the State Department of Education, in others annual meetings of health officers and public health nurses. There are conferences between the Red Cross Director of Public Health Nursing and the Director of Nursing of the State Department of Health, to which the nursing representative is invited, as well as informal visits to the State Departments for one reason or another.

The nursing field representative, at the request of her director, also interviews candidates for positions under the Red Cross, as well as applicants for our scholarship and loan fund. Scholarship nurses are always visited during their course in a school of public health nursing. Disaster relief is another very important duty. It may be a flood, a fire, an epidemic or an earthquake. In case of such a disaster in the representative's territory, she immediately proceeds, on receipt of her orders, to the scene, where under the direction of the National Director of Disaster Relief she assumes the responsibility for the Red Cross nursing group in coöperation with the State Department of Health. This promises always to be a thrilling experience.

Of what the army terms "paper work" there is a generous share. A full and accurate report of each chapter visit, conferences and meetings attended, must be sent to the National Organization as soon as possible. Time is, of course, allowed for this work. An efficiency report on the work, personality and general rating of each nurse goes to the National Director after each visit. Speaking engagements both in the chapters and outside are numerous, and especially heavy during the Roll Call season. All in all it is a busy, interesting, and occasionally, we trust, to someone, a profitable life.

The personal contacts are as interesting and varied as the type of work. One meets with people and customs belonging to every tongue under heaven. One day in the steel industrial districts one sees great sheets of smoke and flame belched forth against the evening sky. Next day one rides amid beautiful mountains and beside broad rivers. And again leaving ice and snow and sleet behind, one catches glimpses of the blue Chesapeake in the distance and willows and maples coming into leaf, and the capers of the little pickaninny on his mule. Best of all is the fine *esprit de corps* found among our nurses, our chapter people and our coworkers. When in the service of "the greatest Mother," all creeds, politics and personalities are forgotten as we work together for the common good. These are the things which make the rough places smooth, coupled with "real love for folks," a sense of humor and the desire to be of genuine service to our fellow-men.

HELEN MAR ERSKINE,
*Nursing Field Representative.*

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After a two months' rest, Miss Jane Van De Vrede will divide her time equally between the Georgia State Nurses' Association, of which she becomes the executive secretary, and the American Red Cross. On May 15 Miss Van De Vrede will assume her duties as a special field representative for the American Red Cross on half time, and will fill special assignments for the National organization in the southern states. The Red Cross rejoices in thus retaining Miss Van De Vrede on its staff even though it had to be on a part-time basis.

Miss Matilda Harris, formerly a nursing field representative in the Southwestern Division and later director of public health nursing for the State Bureau of Public Health of New Mexico, has returned to the Red Cross, and has been appointed nursing field representative in New York state.

Miss Myrtle Flanders, executive secretary and supervising nurse of the Red Cross Chapter, Concord, New Hampshire, has been appointed field representative for New Hampshire, taking the position left vacant by the transfer of Mrs. Lyda King to southern territory.

A number of territorial readjustments are being arranged, and will be announced in the next issue.

# REVIEWS AND BOOK NOTES

## THE PSYCHOLOGY OF THE PRE-SCHOOL CHILD

*By Dr. Bird T. Baldwin and Dr. Lorie I. Stecher*

Appleton & Company, New York City. Price, $2.75.

This book presents the results obtained by the writers from a series of three years' observations and experiments on normal and superior children from two to six years of age in the Pre-School Laboratories of the Iowa Child Welfare Research Station of the State University, Iowa City, Iowa.

The first chapter reviews briefly the literature on the psychology of the young child. The later chapters describe in detail the Pre-School Laboratories and the methods and results of the physical, psychological, educational, and social studies so far completed and a suggestive educational program is outlined for the young child. The appendix contains lists of books, songs, phonograph records, references on physical education and occupational activities, and names of supply houses for material and apparatus.

An attempt has been made to keep in mind constantly the needs of psychologists, physicians, teachers, playground instructors, social workers, and parents who are daily called upon to make practical provision for the needs of child development.

The book contains approximately 250 pages with 60 illustrations.

## THE CARE, CURE AND EDUCATION OF THE CRIPPLED CHILDREN

*By Henry Edward Abt*

Published by the International Society for Crippled Children, Elyria, Ohio, 1924. Price, $3.50.

In this book is given a survey of the present status of the crippled children movement in the United States. The author prepared the original portion of the book as a college thesis in sociology. Because of his familiarity with the subject gained in this study, the International Society for Crippled Children engaged him to expand his work into a form which would be useful in overcoming the great general ignorance of the situation and provide information and suggestions for promotion of crippled children work by interested lay organizations.

The first sixty-five pages are devoted to a rather diffuse discussion of the historical and sociological aspects of the case; the rest of the two hundred and fifteen pages contain a list of medical and educational institutions for crippled children, bibliography, and a very helpful section of sample legislation.

No attempt is made to dictate a plan for conducting crippled children work, but the benefits of the decentralized plan, which brings help to the child rather than taking the child to help, is stressed. The number of children who are physically handicapped is estimated as 342,500 in North America and 264,276 in the United States.

In another book "The Care and Cure of Crippled Children" the situation as found in England is discussed by G. R. Girdlestone. This book is published by John Wright & Sons, 1924.

G. F. Patton, M.D.

## MIDWIFE'S POCKET BOOK

Scientific Press, Ltd., London, England, 1925

The well trained midwife and the obstetrical nurse will find the "Midwife's Pocket Book" a very convenient reference book. It is well illustrated, the various subjects are well outlined and arranged alphabetically and the subject matter is concisely but clearly presented. It contains the Midwives Acts for England, Ireland and Scotland, and the Rules of the Central Midwives Board of Examiners.

However, it might prove a dangerous ally in the hands of our typical rural midwife, whose training at best

is limited to the few classes held in her community by the public health nurse. They are not to be trusted with a midwife bag equipped with needles, hypodermic syringes, ergot and pituitrin, and they are not ready for a discussion of tampons and douches.

HELEN A. MOORE, M.D.

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LIGHTING IN RELATION TO PUBLIC HEALTH

*By Janet Howell Clark, Ph.D.*

Williams & Wilkins Company, 1924.

The necessary physical principles are discussed and the treatment is entirely from the point of view of public health.

Standards of illumination for various conditions of work, designs for factories, schools, homes, and street lighting, glare, and the best conditions for visual efficiency are the principal topics. There also are three chapters on occupational eye diseases and pathologic effects of radiant energy on the eye.—Abstract of review by C. A. Mackay, in *The Journal of Industrial Hygiene.*

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*The May Day Festival Book,* by Grace Hallock, is the most recent publication of the American Child Health Association. Like all Miss Hallock's things it has real charm as well as its definite utilitarian purpose of presenting all sorts of motifs for May Day pageants and festivals. Old costumes and ceremonies of England, France, Roumania, Switzerland and other European countries are here gathered as suggestions for the observances of the revived delightful custom of May Day. Festivals given last year in different states are also given and the book generously provides a new health play, "The Road to Grown Up Town," as well as a good sized bibliography.

Illustrations by Grace L. Schauffler, add to this attractive publication. Price 10 cents, 370 Seventh Avenue, New York City.

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*Mooring Ropes,* the annual report of the Welfare Division of the Metropolitan Life Insurance Company, comes to us in most attractive guise. The cover page presents the Metropolitan Tower "futuristically" treated, making a delightful splash of color. This is the sixteenth year of service of the division, and its many practical accomplishments are pleasantly and interestingly narrated under nautical captions to match the title.

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The Community Health Association of Boston, 502 Park Square Building, has issued a revised edition of their nursing technique—well arranged, simple, clear and efficient. The instructions for care of communicable diseases seem to us especially good. Price, 25 cents.

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The "Winter Issue" of the Bulletin of the International Council of Nurses just published is a monument to the enterprise and selective ability of the Secretary and Editor, Miss Christiane Reimann.

Nursing Education in China, Nursing in Greece, in Hungary, in Peru, in Java, Nursing Legislation in Belgium, are but a few of the articles gathered together from many parts of the globe, and representing many and diverse activities. This is one of the most interesting numbers of the always interesting Bulletin, and is as truly international as it is possible for a nursing magazine to be. Congratulations to Miss Reimann. In our own next number we hope to give some abstracts.

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Recent statistics startle us with the announcement that the highest mortality rate is among women from seventeen to thirty-two years of age. Furthermore the report says that the greater proportion of deaths forming the basis for this rate could have been prevented by a proper regard for the fundamental rules of right living. With these statistics confronting us we again call attention to the *Handbook on Positive Health,* (35 cents a copy), issued by the Women's Foundation for Health, 370 Seventh Avenue, New York City, which sets forth the very fundamentals necessary for correct living. Another valuable addition to

material for adult health education is the Foundation's contribution to the series of twenty books sponsored by the National Health Council, *Exercises for Health,* (30 cents a copy), a pocket-size book containing the principles of constructive health building with emphasis on exercise as adapted to individual use. The little book is attractively illustrated with pin men and contains many of the rules of the Handbook.

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The *Survey Graphic* for March is devoted entirely to *Harlem—Mecca of the New Negro.* The gifts that the dark-skinned people can make to their white brothers have perhaps never before been so dramatically gathered and presented. Verse with a rare freshness, ardor and charm, articles on negro art, the struggle of negro women for sex and race emancipation—"The wind of the race's destiny stirs more briskly because of her striving"—business and educational enterprises, and many other articles and sketches of greater and lesser degree make a symposium of "new" ideas about the negro race not only startling and significant but with a deep and human interest.

THE BLACK FINGER

By ANGELINA GRIMKE

I have just seen a most beautiful thing
Slim and still,
Against a gold, gold sky,
A straight black cypress,
Sensitive,
Exquisite,
A black finger
Pointing upwards.
Why, beautiful still finger, are you black?
And why are you pointing upwards?

*From Opportunity—Reprinted in the Survey Graphic.*

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"When Fathers Drop Out" is one of the series of social and health studies published by the Association for Improving the Condition of the Poor, 105 East 22d Street, New York City. The Study, which covered nine years, was made possible by a grant from the Rockefeller Foundation and the report presents with admirable simplicity the high lights of the experience of the Association in caring for 115 families during the nine years. The "main principles" which have been accepted and followed in the treatment of the families have a very understanding and human note, also the "conclusions" of the writer, William H. Matthews, Director of the Family Welfare Department. Price 20 cents.

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We wonder if our readers have been "noticing" the articles from the fluent and delightful pen of Dr. Frances Sage Bradley, which have been appearing in *The Nation, The Survey, The American Review* and in *Hygeia*—probably in other magazines that we have not seen. Her theme is "The Honest-to-Goodness American Child," in the berry patches, in the lumber camps, in the remote mountain fastnesses, in swamps—in all the out-of-the-way places that the Average American never gives a thought to, but which nevertheless produce small humans to grow up—anyhow, a good deal of the time apparently—into fathers and mothers.

Dr. Bradley, through her studies for the Children's Bureau in the rural and mountain districts of the southern states, later as director of the Arkansas Bureau of Child Hygiene and now as acting director of Child Welfare Division, Montana State Board of Health, knows whereof she speaks and puts her expert knowledge into such dramatic form that even the most indifferent must read and be moved. Dr. Bradley voices for these neglected little ones their wrongs and their despairs, their courage and persistence, as few have ever been able to do.

And the mothers, too! Have a heart, Dr. Bradley implores. Is this great country ever to awake to the simple needs of rural mothers and children? Must the city mother and child have the best medical and surgical care—and the rural ones only what they can get? Is it fair? she asks.

The Nashville, Tennessee, Council for Public Health Nursing—the co-operating agencies of which are the Nashville City Health Department, Metropolitan Life Insurance Company, George Peabody College and the Nashville Community Chest—has produced a cleverly arranged Report of the Nursing Staff for 1924, illustrated with hand drawn charts, photographs and quaint illustrations. The chart showing the Infant Death Rates from 1918 to 1924 shows a reduction from 147 per 1,000 births in 1918, to 89 in 1924. Good work! Our congratulations to Mrs. Ivan Uffelman, Director of Nursing Service, and her Associates.

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The Monthly Bulletin of the Oregon Bureau of Public Health Nursing and Child Hygiene announces that:

A public health nurse has been placed on the Klamath Indian Reservation. This was the outgrowth of a tuberculosis survey made on the reservation two years ago, and the interest aroused in public health nursing by the county nurse in Klamath county. The nurse on the reservation takes the place of a field matron, gives school inspection, makes home visits, instructs mothers and girls in personal and home hygiene. Several crippled children on the reservation have had corrections made through the University of Oregon Medical School.

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A recent number of The Red Cross Courier has a delightful article by Miss Givenwilson, curator of the Red Cross Museum in Washington, on "Man's Loyal Friend, the Dog, in Time of War."

The Courier for March 2nd has an article of unusual interest to the rural nurse, "What the Rural Nurse Owes the Rural Doctor," a frank discussion of unwise as well as wise procedure.

The unknown author concludes her admirable paper with

> I believe that most of the difficulties we public health nurses experience with the doctors are due to four faults of our own:
>
> Our failure to let local doctors take the lead in community public health work,
>
> Our negligence in seeking their points of view,
>
> Our inclination to be sure that the road we map out is the one and only or, at least, the best road,
>
> Finally our tendency to demand immediate results without taking time to consider ultimate results or to diagnose the community's needs and resources.

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The American Red Cross has rounded off its publications by *High School Service,* the first number of which was published in January, 1925. The text and illustrations are delightful and high school children are to be congratulated on this addition to literature devoted specially to their interests. The subscription rate is one dollar a year.

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The February number of *The Modern Hospital* contains the prize essay of the contest on "The Interrelationships of Hospital and Community," written by Mr. Edward A. Fitzpatrick, Marquette University, Milwaukee, Wisconsin. There is much in this admirable presentation of this "neglected problem" that should be of special interest to public health nurses. Among the contestants who received honorable mention was Miss Zella Nicolas, a graduate of the School of Nursing, Mt. Sinai Hospital, New York City, now a student at Teachers' College, Columbia University.

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The Bureau of Child Welfare and Public Health Nursing of the Florida State Board of Health publishes a *Manual of Instruction for Midwives* by Laurie Jean Reid, R.N., director of the bureau. Except for the necessary mandatory paragraphs, it is simply but efficiently arranged in the form of Question and Answer.

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The Library State Centers have each received copies of the Visiting Nurse Study Report. These will be circulated on request. Copies may also be borrowed from the National Health Library, 370 Seventh Avenue, New York City.

# NEWS NOTES

We hear from Detroit the pleasant news that the members of the staff of the Municipal Nurses of Detroit have voted to send Miss Grace Ross to represent them at the meeting in Helsingfors and also to " see Europe " at their expense. Congratulations.

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Mrs. Mary Breckinridge, Number 62,718, as she now appears on the list of certificated English midwives, is the first American nurse to be certified under the Central Midwife Board of England. She has just returned from England after taking a post-graduate course in Midwifery at the School of the York Road Lying-In Hospital, receiving the post Certificate. In addition to her graduate course, which stressed ante-natal and delivery work, Mrs. Breckinridge also took this year a teaching course for midwives through the Midwives Institute, British Hospital, Woolwich, London.

During her stay abroad she visited nursing services in England and Scotland and was greatly impressed by the work of the Queen's Nurses, who, she says, took care last year of 50,000 deliveries, with an average death rate of 1.4.

Two other American nurses, Miss Freda Caffin and Miss Rockstraw, are now taking midwife training in England and will take the national examinations of the Central Midwife Board in June before returning to this country.

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Dr. William H. Walsh has been appointed executive secretary of the American Hospital Association to succeed the late Dr. A. R. Warner. Dr. Walsh held this position during 1917–1918, as the first full-time executive secretary of the association. Dr. Walsh has had extensive hospital and public health experience.

In February the Division of Nursing of the Ohio State Department of Health and the Western Reserve University Nursing District put into effect an exchange of instructors. Miss Catherine M. Forrest of the State Department of Health is exchanging with Miss R. Eleanor Gillespie of the University Nursing District. Such an affiliation will no doubt be of value both to the student and to the public health nurse working in Ohio as well as giving each organization a more complete understanding of the work of each.

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The first annual meeting of the American Heart Association was held in New York City February 2. Dr. Lewis A. Conner, the president, reviewed the progress of the Association and commented on the need for such an organization and the interest developed by its formation. Dr. Haven Emerson, chairman of the Committee on Membership, described the methods employed to reach all parts of the United States and Canada. Already 37 states are represented in the membership of the association. The following program for the coming year was adopted:

*Maintenance of a Central Office* through which all the work of the Association may be organized and directed. This office is already established at 370 Seventh Avenue, New York City, but the personnel must be increased to keep pace with the demands.

*Organization and Membership.* Securing contacts with all parts of the United States and Canada, by appointing regional representatives and obtaining a large and widely distributed membership.

*Educational Work.* Distribution of literature; publication of a monthly Bulletin; lectures; loaning of charts and lantern slides; participation in public meetings of medical and health organizations.

*Field Work.* Workers with a knowledge of the most recent and approved methods for the prevention of heart disease and the organized care of cardiac patients who shall be available to be sent to different sections of the country to encourage the establishment of new centers, demonstrate the

methods found to be effective, and aid in solving local problems.

The following officers were elected by the Board of Directors:

President, Dr. Lewis A. Conner.
Vice-president, Dr. James B. Herrick.
Secretary, Dr. Robert H. Halsey.
Treasurer, Dr. Paul D. White.
Acting Executive Secretary, Miss M. L. Woughter.

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Nurses visiting London this summer will find excellent accommodations at the Royal British Nurses' Club which is situated in Queens Gate, perhaps the most beautiful of any residential street in London. It is close to Kensington Gardens, the favorite pleasure-ground of London's garden-lovers. The house itself is large with bright and spacious rooms, the food is excellent for the moderate charges made, and the popularity of the Club is shown by the fact that it is nearly always full.

It has taken on perhaps more of an international character than any other nurses' club in England, partly because the Royal British Nurses' Association has a large membership abroad. In any case it is one of the features of the Club that it is strictly cosmopolitan. The social side of the Club is extremely well developed. The Secretary and members are always delighted to welcome overseas nurses, and many are the warm friendships which have been brought about through the spirit of good comradeship which exists when the different nationalities foregather at the Club.

The Club is only one of many activities of the Royal British Nurses' Association. Its President is H.R.H. the Princess Arthur of Connaught, the only member of the Royal House in England who is a state-registered nurse. Besides other schemes for the benefit of nurses, the Association has a flourishing private staff (run on coöperative lines) and it has various large benevolent schemes for nurses. For full particulars of the Club application should be made to the Secretary, R.B.N.A. Club, 194, Queen's Gate, London, S. W. 7.

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## NEWS FROM THE STATES

### *California*

An exhibit of dolls dressed in the costume of every age from Bible days down has been prepared by club women of Oakland, California, under the direction of Miss E. P. Whitmarsh and Miss Mabel Rainbow of the Visiting Nurse Association. The dolls, which were first exhibited at the Health Center, are to be shown in window exhibits in the shopping district and will then be loaned to local clubs in Alameda county.

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### *Kentucky*

At the annual meeting of the Public Health Nursing Association of Louisville, Kentucky, held January 28, the staff of the Association gave a demonstration of health teaching in the home to show in a concrete way what is actually being done in Louisville to protect and preserve the health of the community. The demonstration was called "Jimmie's Safe Recovery" and was in two scenes, showing Jimmie and the care provided him during illness and convalescence.

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### *Massachusetts*

At the February meeting of the Western Massachusetts Industrial Nurses Club, held in Springfield, Dr. James A. Seaman spoke on "Hand Infections" and Mr. William Stiles discussed "Endurance."

The March meeting of the club was held in Springfield at Mill No. 3 of the William Carter Company. The members had an opportunity to see silk garments in various stages of manufacture, and a complete line of finished goods. Mr. King, of the Travelers' Insurance Company, was the speaker of the evening.

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### *New York*

The New York Industrial Nurses Club held its January meeting at the Metropolitan Life Insurance Company office. Dr. S. W. Wynne, acting medical director of the hospitals of the Department of Health, talked on the hospital situation in the city.

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The Buffalo District Nursing Association held its annual dinner January 31, with Miss Edna L. Foley, Superintendent of the Chicago Visiting Nurse Association, as the featured speaker. About ninety attended the dinner, in-

cluding members of the nursing staff, the Board of Managers, the Medical Advisory Board and a few invited guests representing the directors of the Nurse Training Schools and city Departments of Health and Dispensaries.

*Ohio*

The Industrial Nurses Club of Cleveland held their regular monthly meeting February 10. Dr. J. E. Grooms of New York City gave an interesting talk on "Goiter and Its Prevention."

At their March meeting the club discussed the question, Health of Nurses in Industry. It was decided to keep an account of lost time due to illness during 1925, and to have the Sick Committee strike off an average number of days lost by the members.

*Texas*

The Dallas (Texas) Association of Public Health Nurses has a Scholarship Loan Fund available for the use of its members who have had at least nine months' experience. The plan is to lend $350 each year, giving the recipient two years in which to repay the Association. The administrative committee of the Fund consists of one business man, one physician, one lay nurse, the president, Mrs. Helen Palmerton, and the secretary-treasurer of the Association.

The Association recently made $500 from a concert, setting aside $350 for the Loan Fund. Monthly meetings are held, with talks on current health topics.

As a member of the Dallas Federation of Women's Clubs, the Association planted a tree in the memorial grove set out by the Federation, naming its tree in honor of Mary Bissett, one of the infant welfare nurses, who left the Association to go as a missionary to China.

## ANNUAL MEETINGS

*Connecticut*

The Connecticut Organization for Public Health Nursing held its nineteenth annual meeting in Hartford, January 30, in a joint three day convention with the Graduate Nurses' Association of Connecticut and the Connecticut League of Nursing Education.

A joint meeting of the three organizations was held January 28 at which Dr. George O'Hanlan, Superintendent of Bellevue and Allied Hospitals, New York City, gave a talk.

On the N.O.P.H.N. day of the convention Miss Stack talked on the bill soon to have a hearing in the legislature "Concerning State Aid to Towns for Public Health Nursing."

Miss Gertrude Osborne, Supervisor of the Hartford V.N.A., gave an interesting account of the "Obstetrical Delivery and Postpartum Work" of her organization. Discussion of the obstetrical delivery services in Connecticut followed.

At the annual business meeting Miss Mary Grace Hills, superintendent of the New Haven V.N.A. and Chairman of the Legislative Committee, presented two bills for the consideration of the meeting, one regarding state aid which will enable small towns in establishing a public health nursing service. The vote was unanimous in favor of the bill.

The second bill, concerning commitments to the Connecticut State Farm for women, was unanimously opposed. Mr. Frederick L. Hoffman, consulting statistician of the Prudential Insurance Company of America, spoke on "Some Essentials of Public Health Nursing."

The following officers were elected:

President: Miss Margaret Barrett, New Haven.

First Vice-President: Miss Louise Spence, Bridgeport.

Second Vice-President: Miss Abbie Gilbert, Middletown.

Secretary and Treasurer: Miss Mabel Macdonell, Stamford.

Councillors: Misses Evelyn Law, Madison; Margaret K. Stack, Hartford; Elizabeth Smith, Wallingford; Lucy Bartram, Terryville; and Mrs. Nancy Kromer, Montville.

*Maryland*

The Public Health Nurses Association of Maryland held its annual meeting

ANNUAL MEETINGS—*Con.*

in Baltimore in joint session with the State League of Nursing Education and the State Nurses Association, January 27–29. Practical demonstrations were held at Johns Hopkins University and Hospital, and there were clinics and lectures at hospitals and the Baltimore Health Department. A lecture of particular interest to public health nurses was that by Dr. Allen W. Freeman, Director of the Johns Hopkins School of Hygiene, on the opportunity afforded the nurse by public health work.

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*Oregon*

The annual meeting of the Oregon State Organization for Public Health Nursing was held in Portland February 27 and 28, immediately following the annual convention of the Oregon Tuberculosis Association. The two organizations held a joint session one evening, at which Dr. Walter H. Brown, who is at the head of the Marion County (Oregon) Child Health Demonstration, was the principal speaker.

The program of the State Organization meeting included:

Health and Recreation in the Hop Yards, Mr. Jack Henderson; Mental Hygiene, Miss Elnora E. Thomson; Responsibility of the Nurse for Promoting Other Fields of Social Welfare, Miss Aleta Brownlee; Symposium, "The Family," with the point of view of the family doctor interpreted by Dr. V. E. Dudman, that of the nurse by Miss Helen Hartley, the teacher by Miss Anne Thompson, and the social worker by Miss Emma M. Dubruille; Little Mothers' League, Miss Margaret Lynch; The County Health Unit, Miss Lydia Fricke; The Present Status of Diphtheria and Scarlet Fever Control, Dr. William Levin.

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*Rhode Island*

The Rhode Island State Organization for Public Health Nursing held its annual meeting in Providence, February 19, beginning with two round tables, one of the Lay Members' section, the other on the Report of the Committee to Study Visiting Nursing. Mary I. McCarthy, Mary M. Richardson and Mrs. Anna Castle discussed "What My Course in Public Health Nursing Has Meant."

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The sixth quinquennial convention of the International Council of Women will be held in Washington, May 4–14. The International Council is made up of National Councils of thirty-six countries, with a membership of thirty-six million women. The National Council of the United States includes forty national organizations with a membership of twelve million women.

Founded in Washington in 1888, the particular object of the Council is a promotion of unity and mutual understanding between all associations of women working for the common welfare of humanity. It is hoped that this convention will be a decisive step toward world peace. Former conventions have been held in Christiania, Rome, London, Berlin and Geneva, and it will be two hundred years before another convention of the International Council will be held in this country.

Some of the outstanding features of the program will be a discussion of "Present-Day Standards in Life and Industry," with the president of the Council, the Marchioness of Aberdeen and Temair, as chairman; a pageant of Peace and War; an evening devoted to "Recent Developments in Citizenship"; a discussion of "Social Ideals in International Life."

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The first Woman's World Fair will be held in Chicago April 18-25, with the following types of exhibits:

Women from diversified countries of the world and from all sorts of occupations will show what they are doing and what they have accomplished in business, trades, professions and arts.

The development of women in social, civic, and club organizations will be shown from various countries and peoples.

Merchants, manufacturers, and growers of products that are of interest to women will exhibit their wares.

The Chicago Visiting Nurse Association has taken a booth and hopes to draw much attention. A special committee, composed of Miss Edna L. Foley, Superintendent of the Association, and three of the directors, is in charge of the booth.